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ABSTRACT

The first of a 3-volume series describing the 17 Early Head Start (EHS) programs in fall 1997, this report discusses the main features of the research programs and identifies the key challenges and successes they experienced during their first year of serving families. Chapter 1 of the report discusses the historical and national context of the first years of Early Head Start, including public policy issues and the proposed evaluation. Chapter 2 describes the programmatic approaches, community contexts, and expected outcomes of the new programs, as well as the characteristics of the families enrolling in the new EHS program. Chapter 3 identifies the program activities and services being delivered within the first year of serving families as they relate to recruitment, enrollment, child development, family development, staff development, community partnerships, and program management. Chapter 4 summarizes the challenges and highlights successes experienced by the new programs. The report concludes by noting that discussions of goals, strategies, and expected outcomes can be useful to developing programs and to researchers. The EHS programs participating in the early evaluation research can pave the way for later programs by sharing the lessons they have learned and by engaging in a partnership with researchers that will enhance the relevance and usefulness of the evaluation research. (Contains 21 references.) (KB)

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Early Head Start
Research and Evaluation Project
Local—National Partnerships

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Leading the Way: Characteristics and Early Experiences of Selected Early Head Start Programs

Volume I: Cross-Site Perspectives

December 1999

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The Commissioner's Office of Research and Evaluation
And the Head Start Bureau
Administration on Children, Youth and Families
Department of Health and Human Services

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Early Head Start Implementation Study Reports and Primary Research Questions

***Leading the Way* Report:** *What were the characteristics and implementation levels of 17 EHS programs in fall 1997, soon after they began serving families?*

Executive Summary *Summarizes Volumes I, II and III.*

Volume I: *Cross-Site Features--What were the characteristics of EHS research programs in fall 1997, across 17 sites?*

- *Chapter I:* *What was the historical and national context of the first years of Early Head Start?*
- *Chapter II:* *What were the programmatic approaches, community contexts, and expected outcomes of the new programs? What were the characteristics of the families enrolling in the new Early Head Start programs?*
- *Chapter III:* *What program activities and services were the new programs delivering within the first year of serving families?*
- *Chapter IV:* *What challenges and successes did the new programs experience?*

Volume II: *Program Profiles--What were the stories of each of the EHS research programs?*

Volume III: *Program Implementation--To what extent were the programs fully implemented, as specified in the revised Head Start Program Performance Standards, by fall 1997?*

***Pathways to Quality and Full Implementation* Report:** *What were the characteristics, levels of implementation, and levels of quality of the 17 EHS programs in fall 1999, three years into serving families? What pathways did programs take to achieve full implementation and high quality? This report will be released in early 2000.*

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I. INTRODUCTION

Early Head Start has blossomed from a fledgling program with 68 grantees in 1995 into today's national initiative, with more than 500 grantees around the country, an increasing proportion of the Head Start budget (from 3 percent in 1995 to 10 percent in 2002), strong bipartisan support, and support from the administration.[1] Seventeen of these programs are participating in national and local research and evaluation studies that are documenting the implementation process and assessing program impacts and outcomes. The Administration on Children, Youth and Families (ACYF) envisions these research programs as leading the way by providing information that will promote improvements and inform further expansion of Early Head Start nationally. As part of the first group of Early Head Start programs funded, the 17 research sites are in the forefront in designing and implementing programs that meet the revised Head Start Program Performance Standards (U.S. Department of Health and Human Services 1996). As participants in the Early Head Start National Research and Evaluation Project, they are demonstrating what Early Head Start programs can accomplish. They are also sharing the lessons they have learned in creating Early Head Start programs and in developing high-quality services for infants and toddlers and their families.

The Early Head Start programs are dynamic, and they operate in a changing world. This report describes the programs as they existed in fall 1997. Many programs were making changes at that time and are continuing to make changes.[2] Since fall 1997, the revised Head Start Program Performance Standards have become official and the programs have received monitoring visits. The second implementation study report, to be completed in early 2000, will assess the process of program change and development over the first four years of Early Head Start program funding

---

[1] At the October 23, 1997, White House Conference on Child Care, President Clinton announced his proposal to double Early Head Start funding.

[2] Where programs were making changes or experiencing changed circumstances at the time of the site visits, the profiles in Volume II describe the changes that were under way.

In this introductory chapter, we review the beginnings of Early Head Start, describe the current policy context in which the programs are being implemented, and summarize the plans for the evaluation. The following chapters provide an overview of the 17 Early Head Start research programs in fall 1997, relate what we have learned about the programs' theories of change (concentrating on their goals, priorities, and expected outcomes), provide detailed documentation of the services offered by the programs within the first two years of funding, and analyze the key challenges that Early Head Start programs faced and the successes they achieved in the early stages of implementation.

A. THE EARLY HEAD START PROGRAM AND ITS POLICY CONTEXT

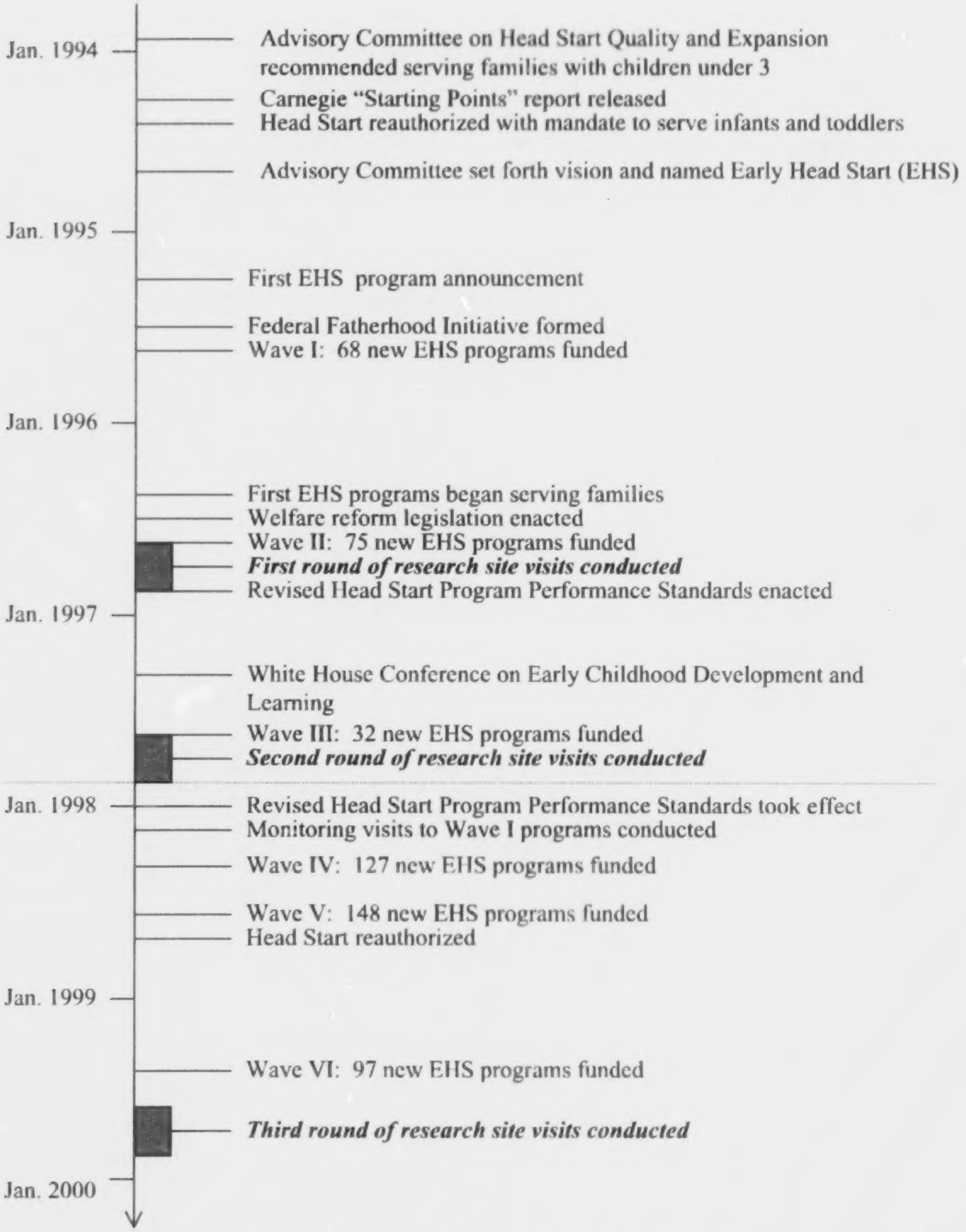
New initiatives and programs are shaped by the trends and events that lead to their creation and by the policy context in which they are developed. In the case of Early Head Start, several important events led to the development of a program for low-income families with infants and toddlers. During the program's early phase, important changes occurred both in social policy and in our understanding of program effectiveness, which may dramatically influence the program's development and future direction. The rest of this section examines key influences on the initial conception and early implementation of Early Head Start. Figure I.1 illustrates the timing of the key events discussed next.

1. The Beginnings of Early Head Start

Early Head Start began at a time of increasing awareness of the "quiet crisis" facing families with infants and toddlers in the United States, as identified in a report entitled "Starting Points:

FIGURE I.1

KEY EVENTS IN THE IMPLEMENTATION OF EARLY HEAD START


Jan. 1994
Advisory Committee on Head Start Quality and Expansion recommended serving families with children under 3
Carnegie "Starting Points" report released
Head Start reauthorized with mandate to serve infants and toddlers
Advisory Committee set forth vision and named Early Head Start (EHS)
Jan. 1995
First EHS program announcement
Federal Fatherhood Initiative formed
Wave I: 68 new EHS programs funded
Jan. 1996
First EHS programs began serving families
Welfare reform legislation enacted
Wave II: 75 new EHS programs funded
First round of research site visits conducted
Revised Head Start Program Performance Standards enacted
Jan. 1997
White House Conference on Early Childhood Development and Learning
Wave III: 32 new EHS programs funded
Second round of research site visits conducted
Jan. 1998
Revised Head Start Program Performance Standards took effect
Monitoring visits to Wave I programs conducted
Wave IV: 127 new EHS programs funded
Wave V: 148 new EHS programs funded
Head Start reauthorized
Jan. 1999
Wave VI: 97 new EHS programs funded
Third round of research site visits conducted
Jan. 2000

Events below the dotted line occurred after the site visits that provided data for this report. These events are included in the timeline to demonstrate the dynamic nature of Early Head Start program development.

Meeting the Needs of Our Youngest Children" by the Carnegie Corporation of New York (1994). As the report showed, large numbers of infants and toddlers are starting life in poor environments, without adequate stimulation, and without sufficient interactions with caring, responsive adults. The release of "Starting Points" followed closely on a comprehensive self-examination of Head Start services conducted by the Advisory Committee on Head Start Quality and Expansion. This committee called for Head Start programs to improve their quality, address the fragmentation of services by forging new partnerships, and expand services in a number of ways, including serving more families with infants and toddlers (U.S. Department of Health and Human Services 1993). Subsequently, the Head Start Authorization Act of 1994 mandated new Head Start services for families with infants and toddlers, authorizing 3 percent of the total Head Start budget in 1995, 4 percent in 1996 and 1997, and 5 percent in 1998 for these services (U.S. Department of Health and Human Services 1994a). The Coats Human Services Reauthorization Act of 1998 further expanded the program, setting aside 7.5 percent of Head Start funds in 1999, 8 percent in 2000, and 10 percent in 2001 and 2002 for Early Head Start programs (U.S. Department of Health and Human Services 1998).

In 1994, Donna Shalala, Secretary of the U.S. Department of Health and Human Services, created the Advisory Committee on Services for Families with Infants and Toddlers, which provided the guidelines for the new Early Head Start program (U.S. Department of Health and Human Services 1995). The report of the Advisory Committee set forth a vision and blueprint for Early Head Start programs and established principles and cornerstones for the new program (U.S. Department of Health and Human Services 1994b).

Early Head Start programs are comprehensive. The Advisory Committee on Services for Families with Infant and Toddlers envisioned a two-generation program that included intensive services that begin before the child is born and concentrates on enhancing the child's development and supporting the family during the critical first three years of the child's life. The Advisory Committee recommended that programs be designed to produce outcomes in four domains:

1. ***Children's development*** (including health, resiliency, social competence, and cognitive and language development)
2. ***Family development*** (including parenting and relationships with children, the home environment and family functioning, family health, parent involvement, and economic self-sufficiency)
3. ***Staff development*** (including professional development and relationships with parents)
4. ***Community development*** (including enhanced child care quality, community collaboration, and integration of services to support families with young children)

The program guidelines specify that grantees may design programs that achieve these outcomes by conducting home visits, providing center-based child development services, combining these approaches, or implementing other locally designed options.

Early Head Start is designed for low-income pregnant women and families with infants and toddlers. The program guidelines specify that programs may serve pregnant women and families that contain at least one child under age 3 and that meet the Head Start income criteria. Although most families must have incomes at or below the federal poverty level or be eligible for public assistance, programs may serve up to 10 percent of children from families that do not meet these income criteria. Programs are also required to make at least 10 percent of the spaces available to children with disabilities.

The first wave of grantees--68 local programs--were funded in September 1995. Another 75 programs were funded in September 1996, and more were funded in subsequent years, so that today more than 500 programs are serving infants and toddlers and their families.

ACYF created an infrastructure for supporting the new programs, including (1) training and technical assistance, (2) revised Head Start Program Performance Standards, and (3) monitoring of programs to ensure compliance with the standards. The Early Head Start National Resource Center is providing ongoing support, training, and technical assistance to all waves of Early Head Start programs under a contract with Zero to Three. The center has provided training known as "intensives" in infant-toddler care; week-long training for key program staff; annual institutes in Washington, DC, for key program staff; and identification and preparation of a cadre of nationally known infant-toddler consultants who work intensively with programs on a one-to-one basis. The Early Head Start National Resource Center has worked closely with regional training grantees--the Head Start Quality Improvement Centers (HSQICs) and the Head Start Disabilities Services Quality Improvement Centers (DSQICs)--and with their infant-toddler specialists, as well as the 10 U.S. Department of Health and Human Services Regional Offices and Indian and Migrant branches that assumed responsibility for administrating Early Head Start grants in fiscal year 1998.

Early Head Start programs follow and are monitored according to the revised Head Start Program Performance Standards. The revised Head Start Program Performance Standards were developed in an extensive process that took several years and included commentary by thousands of experts in early education, health, and related areas; Head Start parents and staff members; and members of the general public. At the time of the site visits in fall 1997, the revised Head Start Program Performance Standards had been published and would take effect in January 1998, and the programs were still seeking clarification of some of the new regulations.

Head Start Bureau monitoring teams visit programs every three years to determine whether they are in compliance with program guidelines and the revised Head Start Program Performance Standards. Initially, the national office of the Head Start Bureau was responsible for awarding program grants and overseeing program operations. In fall 1997, however, this responsibility was transferred to the 10 U.S. Department of Health and Human Services Regional Offices, except for a limited number of programs involving special circumstances. Wave I Early Head Start programs were first monitored in spring 1998.

2. The Policy Context for Early Head Start Implementation

The implementation of any large-scale initiative cannot be understood without examination of the context in which it operates. The Early Head Start initiative is being implemented during a time of fundamental changes in this country's social services systems. Some of these changes may have a dramatic effect on the approaches programs take, the ways in which families respond, and the ways in which programs interact with others in their communities. In particular, five broad social changes and contextual factors, some of which occurred after Early Head Start began, may influence the Early Head Start initiative: (1) increasing recognition of the importance of early development, (2) welfare reform in the context of a strong economy, (3) new child care and pre-kindergarten initiatives, (4) growing attention to the roles of fathers in young children's lives, and (5) recent evaluation findings that identify challenges in improving outcomes for children and families.

Early Development. Recent research has shown that human development prior to birth and during the first year of life is rapid and extensive and vulnerable to environmental influences. Moreover, early development has a long-lasting effect on children's cognitive, behavioral, and physical development (Carnegie Corporation of New York 1994). National attention focused on early brain development in spring 1997, when the White House convened the Conference on Early Childhood Development and Learning and special editions of national news magazines featured articles on infant brain development. The increasing focus on the importance of early development may lead program staff to adopt strategies and plan activities that are more child-focused, and increasing awareness among policymakers, program sponsors, and community members may lead to greater demand and support for services that start when women are pregnant and focus directly on child development.

Welfare Reform. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which became effective just as Early Head Start began serving families, reformed federal welfare policy and gave states more autonomy and responsibility for setting and administering welfare policy. It also established clear expectations for families receiving welfare. Cash assistance is now provided through the Temporary Assistance for Needy Families (TANF) program and is no longer an entitlement. Adults may receive cash assistance for a maximum of 60 months over their lifetime. After two years (or less time, at state option), many families will have to work in order to continue receiving cash assistance. Some states exempt parents of infants from the work requirements for a short time (typically less than a year), but many do not.

For delivery of program services, PRWORA created a climate different from the one that had existed when the first wave of Early Head Start grantees wrote their proposals. The new work requirements and time limits on cash assistance may increase demands on parents' time, increase their child care needs, increase levels of family stress, and make it more difficult for parents to participate in some program services. The new requirements may also make parents more receptive to employment-related and child care services and motivate them to find jobs and become self-sufficient. Thus, in the context of the strong U.S. economy, they may improve families' economic well-being. The increasing need for good infant/toddler child care may put extra pressure on Early Head Start programs to provide full-day, full-year child care or to help develop and support it in their communities.

New Child Care and Pre-Kindergarten Initiatives. PRWORA also consolidated federal funding for child care into a new Child Care and Development Fund (CCDF), which provides increased funding for child care for low-income families and allows states to design comprehensive, integrated child care delivery systems. These changes may make it easier for families who need child care to obtain financial assistance and make it easier for Early Head Start staff members to help families obtain child care subsidies. The increased employment of low-income families under PRWORA may also increase the need for Early Head Start staff members to collaborate with state child care administrators and local providers to help meet families' child care needs and may challenge staff members to blend funds and find ways to work with the child care system within their states and communities.

In addition to child care subsidies for low-income families, 37 states now provide funds for a pre-kindergarten program or have a school funding mechanism for 4-year-olds (Mitchell, Ripple, and Chanana 1998). Shifting resources and increased support for the care of preschool children in many areas may offer Head Start and other preschool programs more opportunities for blending funding sources and may free up resources for serving more families with infants and toddlers. Where early childhood labor markets are tight, these initiatives may also make it more difficult for Early Head Start programs to hire and retain trained staff members.

The Role of Fathers. Policymakers, researchers, and educators are assuming a new, more explicit focus on fathers. Fathers are key partners in contributing economic and emotional support for the development of their children. As a consequence, to promote the positive involvement of fathers in the lives of their children, federal agencies are developing and enhancing fatherhood policies. This shift is related to recent social trends and the federal Fatherhood Initiative.[3]

The growing attention to the roles of fathers may lead programs to devote more program resources than originally planned to strengthening fathers' relationships with their children and enhancing their parenting skills. Changing patterns of father involvement also challenge programs to develop creative strategies for father involvement that are not limited by traditional conceptions of family structure.

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[3] The federal Fatherhood Initiative was galvanized by President Clinton's request for federal agencies to assume greater leadership in promoting the involvement of fathers and focusing on their contributions to their children's well-being. The activities of this initiative have involved the White House, several key federal statistical agencies, the Family and Child Well-Being Research Network (a consortium of seven scholars funded by the National Institute of Child Health and Human Development--NICHD) and the National Center on Fathers and Families. Together, these activities have created a national momentum for reconceptualizing the way fathers are incorporated into policies. They also have set forward a research agenda that will improve federal data on fathers and will support the development of policies that recognize the emotional, psychological, and economic contributions that fathers can make to the development of their children.

Recent Program Evaluation Findings. The Early Head Start programs began just as new findings from evaluations of programs that served families with infants and toddlers during the 1980s and early 1990s were being released. In particular, the longer-term findings of the evaluation of ACYF's Comprehensive Child Development Program (CCDP) were released soon after the first Early Head Start programs were funded. The CCDP, which offered case management services to low-income families with infants and toddlers, had few impacts on child and family outcomes (except in a few sites). In addition, recent research suggests that home-visiting programs often may not be effective and that careful attention needs to be paid to their implementation (Olds et al. 1998; and Gomby, Culross, and Behrman 1999).

The recent research findings highlight the difficulty of improving the lives of low-income children and families, but they also provide lessons to build on. The recent CCDP findings, along with previous research results, suggest that programs that provide intensive, purposeful, high-quality, child-focused services are more likely than those that provide primarily adult-focused services to promote significant changes in children's cognitive, social, and emotional development. Accordingly, ACYF is directing Early Head Start programs to emphasize child development services--direct services to children in child development centers or home visits--and to pay careful attention to the quality of children's child care arrangements, in addition to supporting parents as their children's primary educators. ACYF strongly supports continuous program improvement in Early Head Start by providing intensive training and technical assistance, drawing on early research findings in its training and technical assistance activities, and supporting program partnerships with local researchers.

B. OVERVIEW OF THE EARLY HEAD START EVALUATION

The Early Head Start Research and Evaluation Project includes a national evaluation being conducted in tandem with local research and evaluation studies to address a broad range of issues. The project is assessing program impacts on an extensive set of child and family outcomes. In addition, it is investigating the role of program and contextual variations, studying the pathways to program quality, examining the pathways to desired child and family outcomes, and creating the foundation for a series of longitudinal research studies.

To achieve its aims, the Early Head Start Research and Evaluation Project encompasses five major components:

1. ***An implementation study*** to examine service needs and use for low-income families with infants and toddlers, assess program implementation, understand programs' theories of change, illuminate pathways to achieving quality, examine program contributions to community change, and identify and explore variations across sites

2. ***An impact evaluation,*** using an experimental design to analyze the effects of Early Head Start programs on children, parents, and families; descriptive analyses will assess outcomes for program staff and communities. Early Head Start programs that are participating in the national evaluation recruited 150 to 200 families with pregnant women or children under age 1 to participate in the impact evaluation research (half were randomly selected to participate in the program, and half were randomly assigned to the control group).

3. ***Local research studies*** to learn more about the pathways to desired outcomes for infants and toddlers, parents and families, staff, and communities

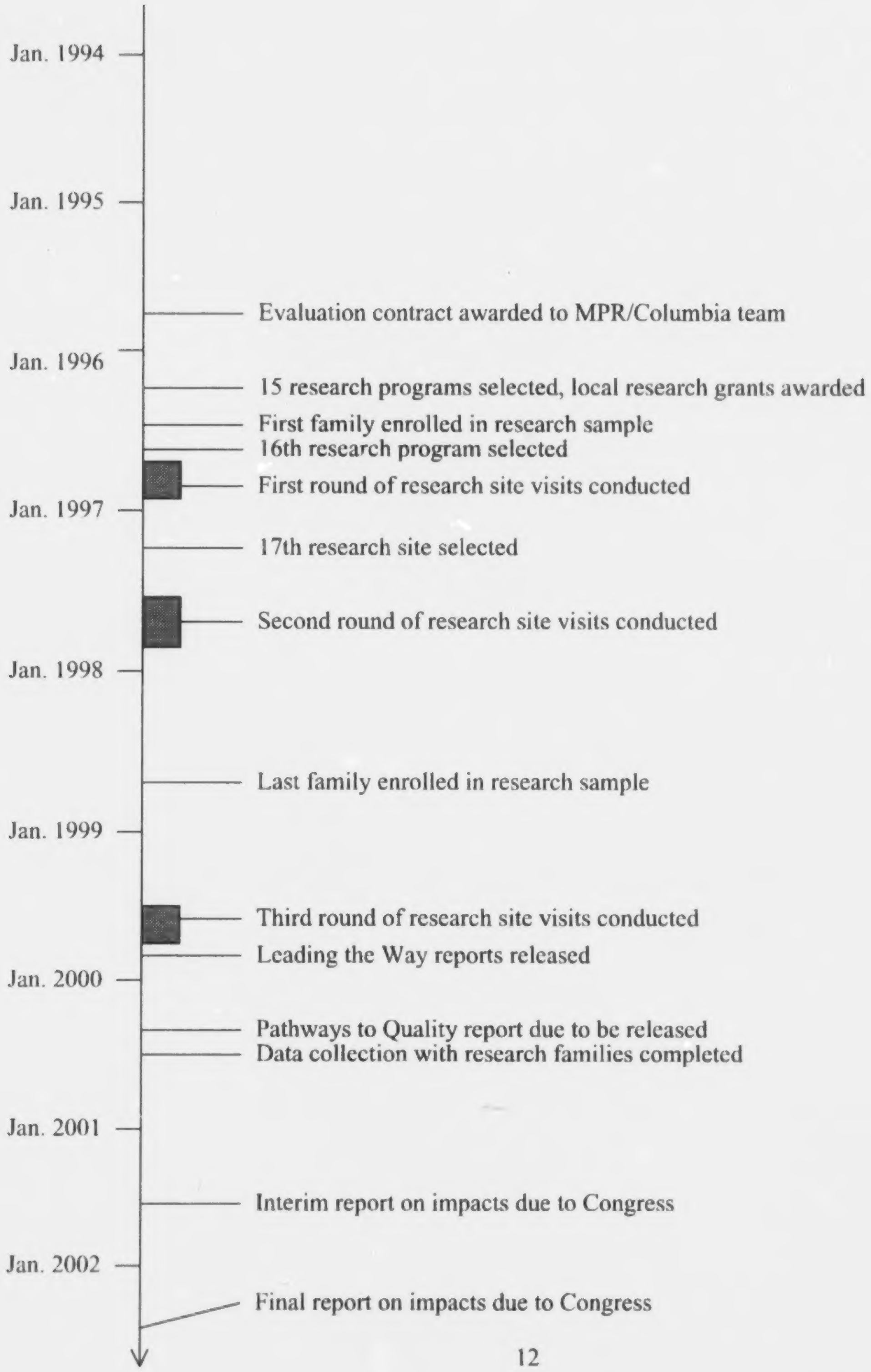
4. ***Policy studies*** to respond to information needs in areas of emerging policy-relevant issues, including welfare reform, fatherhood, child care, and children with disabilities

5. ***Continuous program improvement*** activities to guide all Early Head Start programs in formative evaluation

Figure I.2 presents a timeline that describes the key evaluation events and milestones.

FIGURE I.2

KEY EVENTS IN THE EARLY HEAD START EVALUATION


Jan. 1994
Jan. 1995
Evaluation contract awarded to MPR/Columbia team
Jan. 1996
15 research programs selected, local research grants awarded
First family enrolled in research sample
16th research program selected
First round of research site visits conducted
Jan. 1997
17th research site selected
Second round of research site visits conducted
Jan. 1998
Last family enrolled in research sample
Jan. 1999
Third round of research site visits conducted
Leading the Way reports released
Jan. 2000
Pathways to Quality report due to be released
Data collection with research families completed
Jan. 2001
Interim report on impacts due to Congress
Jan. 2002
Final report on impacts due to Congress

In 1996 and early 1997, ACYF selected 17 programs to participate in the national research and evaluation project. All Early Head Start programs funded in the first and second waves had agreed to participate in a random assignment evaluation. In January 1996, ACYF invited Wave I programs to select research partners and subsequently to apply to be a research site. To be eligible, they had to guarantee that they could recruit 150 families for EHS research (twice their program capacity). For easier identification of research partners, the Society for Research in Child Development made directories of its membership available to each new Early Head Start program, and ACYF issued a request for proposals, including the addresses and contact persons for the 68 Wave I programs, to notify researchers of the research opportunity. Forty-one program-researcher partnerships submitted proposals to be research sites (many of the other programs could not meet the sample size requirement). In all, ACYF selected 15 partnerships, basing its choices on both the quality of the proposed local research and an effort to achieve a balance of rural and urban locations, racial/ethnic composition, and program approaches. Subsequently, ACYF added two sites, one from the Wave II programs, to provide the desired balance of approaches. Chapter II provides an overview of the selected programs.

C. THIS REPORT IN THREE VOLUMES

This is the first of two reports that will detail findings from the implementation study. The first report consists of three volumes and describes the programs as of fall 1997. It discusses the main features of the research programs and identifies the key challenges and successes they experienced during their first year of serving families (Volume I), presents detailed profiles of each of the 17 programs (Volume II), and analyzes program implementation in each domain (Volume III). The second implementation report will present an analysis of implementation and quality after a round of site visits in late summer 1999 and discuss the pathways to higher quality followed by the research programs.

The data for this report come from many sources, including two rounds of site visits to the research programs, program documents, self-administered staff surveys, Head Start Family Information System application and enrollment forms, and other documents and databases. The site visits were conducted by researchers from Mathematica Policy Research, Inc. and Columbia University's Center for Young Children and Families. The first round of site visits was conducted in summer and early fall 1996, around the time most programs began serving families. The second round of site visits was conducted in fall 1997, approximately two years after the programs were funded and one year after they began serving families.

The information gathered from various sources was synthesized using established qualitative analysis methods and systematic procedures established in advance. Site visitors used notes they took during their visits to prepare a narrative profile of each program and to complete tables displaying key information about each program in a consistent format. These profiles and tables were verified by program directors. Analysts then created cross-site data displays showing related information for each site. These cross-site data displays facilitated the tabulation and interpretation of the data. We verified our conclusions through discussions with site visitors and ACYF staff members.

Descriptive statistical methods, including calculating means and frequencies, were used to analyze quantitative data. Data on families' characteristics from the Head Start Family Information System application and enrollment forms and data from the self-administered staff surveys were analyzed using these methods.

The following chapters present a comprehensive description of the Early Head Start research programs in fall 1997. Chapter II describes the Early Head Start research programs and the families they served, examines how representative they are of all Wave I and II Early Head Start programs, and discusses the programs' goals, priorities, and expected outcomes. Chapter III describes program recruitment and enrollment, the services provided by the programs, and program management. Chapter IV summarizes the key challenges the research programs faced in their first year of serving families and highlights their early strengths and successes.

II. OVERVIEW OF THE EARLY HEAD START RESEARCH PROGRAMS

The Early Head Start research programs built on diverse experiences, served families from different backgrounds, and in fall 1997 were taking a variety of approaches to serving children and families. Early Head Start programs strive to achieve their goals by designing program options based on family and community needs. Programs may offer one or more options to families, including: (1) a home-based option, (2) a center-based option, (3) a combination option in which families receive a prescribed number of home visits and center-based experiences, and (4) locally designed options, which in some communities include family child care. Because a single program may offer multiple options to families, for purposes of the research, we have characterized *programs* according to the options they offer to *families* as follows:

- ***Center-based programs***, which provide all services to families through the *center-based option* (center-based child care plus other activities)
- ***Home-based programs***, which provide all services to families through the *home-based option* (home visits plus other activities)
- ***Mixed-approach programs***--which provide services to some families through the *center-based option* and some families through the *home-based option*, or provide services to families through the *combination option* or *locally designed option*

This chapter presents the history and approaches of the Early Head Start research programs, describes the communities in which they operate, provides a portrait of the families enrolled in the programs, and examines the extent to which these programs reflect the characteristics of all the Early Head Start programs funded in the first two waves. It also explores the goals, expected outcomes, and theories of change the research programs had adopted as of fall 1997. The next chapter will describe program activities and services in detail.

A. BACKGROUND OF THE RESEARCH PROGRAMS

The Early Head Start research program grantees were at various stages of implementing services for infants and toddlers and incorporating Head Start program features at the time they were funded. Nine of the Early Head Start research program grantees had operated Head Start programs, and of these, five had served infants and toddlers in the past. One of the new Early Head Start research program grantees had operated a Parent Child Center (PCC), as well as a Head Start program. Seven of the new Early Head Start research programs had operated Comprehensive Child Development Programs (CCDPs). All of these programs had provided services to infants and toddlers before, but five of them were new to Head Start. Three of the new Early Head Start program grantees had not operated Head Start programs, CCDPs, or PCCs but had operated other community-based programs. These grantees include a Montessori program that had previously served infants, toddlers and preschool children, as well as a school district and a well-known national agency that had not previously served infants or toddlers (Table II.1).

When they were initially funded, similar numbers of programs were center-based (five programs), home-based (five programs), and mixed-approach (seven programs). By fall 1997, eight programs were home-based, four were center-based, and five were mixed-approach programs (Figure II.1). These changes in approach resulted from subsequent funding decisions, changes in families' needs, and recommendations of technical assistance providers. Several programs are continuing to make changes in their basic approaches.

The research programs are distributed fairly evenly across all major regions of the country and across rural and urban areas. Six programs, three of which are center-based or mixed-approach programs, are located in western states (California, Washington, Colorado, and Utah). Four, all home-based programs, are in midwestern states (Iowa, Kansas, Michigan, and Missouri). Four programs, three of which are center-based or mixed-approach programs, are in northeastern or

TABLE II.1

OVERVIEW OF EARLY HEAD START RESEARCH PROGRAMS

Program	Grantee	Local Research Partner	Location	Previous Experience	Approach
DHHS Region 1					
Early Education Services (Brattleboro, VT)	School district	Harvard University	Small town/ rural	CCDP	Mixed
DHHS Region 2					
The Educational Alliance (New York, NY)	Community-based social services agency	New York University	Urban	Head Start	Center-based
DHHS Region 3					
Family Foundations (Pittsburgh, PA)	University	University of Pittsburgh	Urban/ small town	CCDP	Home-based
United Cerebral Palsy (Alexandria, VA)	National agency providing services to individuals with disabilities	Catholic University of America	Urban	New program	Mixed
DHHS Region 4					
Sumter School District 17 (Sumter, SC)	School district	Medical University of South Carolina	Small town/ rural	Title I preschool program	Mixed
Northwest Tennessee Head Start (McKenzie, TN)	Community action agency	None	Small town/ rural	Head Start	Center-based
DHHS Region 5					
Region II Community Action Agency (Jackson, MI)	Community action agency	Michigan State University	Urban	Head Start, infant mental health program	Home-based
DHHS Region 6					
Child Development, Inc. (Russellville, AR)	Community-based child development organization	University of Arkansas, Little Rock	Small town/ rural	Head Start, Parent Child Center	Center-based

TABLE II.1 *(continued)*

Program	Grantee	Local Research Partner	Location	Previous Experience	Approach
DHHS Region 7					
Mid-Iowa Community Action (Marshalltown, IA)	Community action agency	Iowa State University	Rural	CCDP, Head Start	Home-based
Project EAGLE (Kansas City, KS)	University medical center	University of Kansas	Urban	CCDP	Home-based
KCMC Child Development Corporation (Kansas City, MO)	Community-based child development organization	University of Missouri, Columbia	Urban	Head Start	Home-based
DHHS Region 8					
Family Star (Denver, CO)	Community-based Montessori program	University of Colorado Health Sciences Center	Urban	Infant-preschool Montessori program	Center-based
Clayton Mile High Family Futures Project (Denver, CO)	Partnership between a foundation and a child care resource and referral agency	University of Colorado Health Sciences Center	Urban	CCDP, Head Start	Mixed
Bear River Head Start (Logan, UT)	Head Start agency	Utah State University	Small town/ rural	Head Start	Home-based
DHHS Region 9					
The Children First (Venice, CA)	Private community health clinic	University of California, Los Angeles	Urban	CCDP	Home-based
DHHS Region 10					
Families First (Kent, WA)	Community-based child welfare agency	University of Washington School of Nursing	Suburban/ small town	CCDP	Mixed
Washington State Migrant Council Early Head Start (Sunnyside, WA)	Community-based organization serving migrant families	University of Washington College of Education	Rural	Migrant Head Start	Home-based

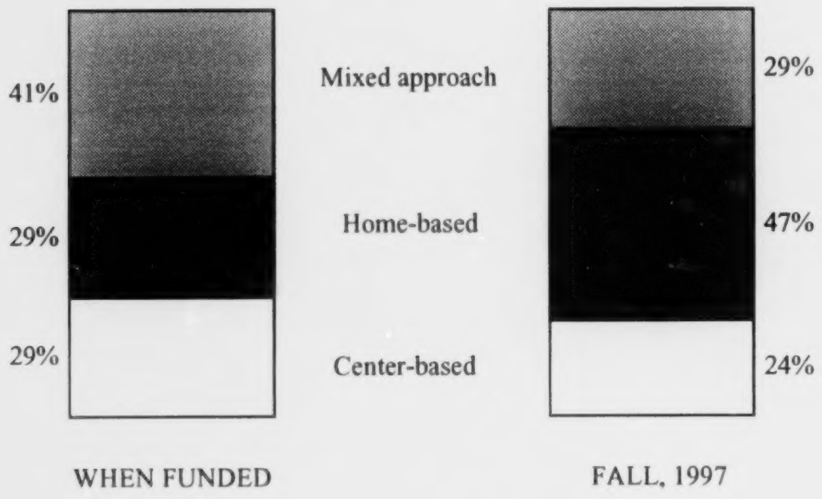
SOURCE: Preliminary Head Start Family Information System application and enrollment data.

NOTE: For purposes of this report, "mixed approach" includes programs that serve some families through a center-based option and some through a home-based option, as well as those serving families through a combination option that provides a prescribed number of home visits and center-based experiences.

CCDP = Comprehensive Child Development Program.

FIGURE II.1

PROGRAM APPROACHES IN THE EARLY HEAD START RESEARCH PROGRAMS



SOURCE: Information gathered during visits to the Early Head Start research programs in the fall of 1997.

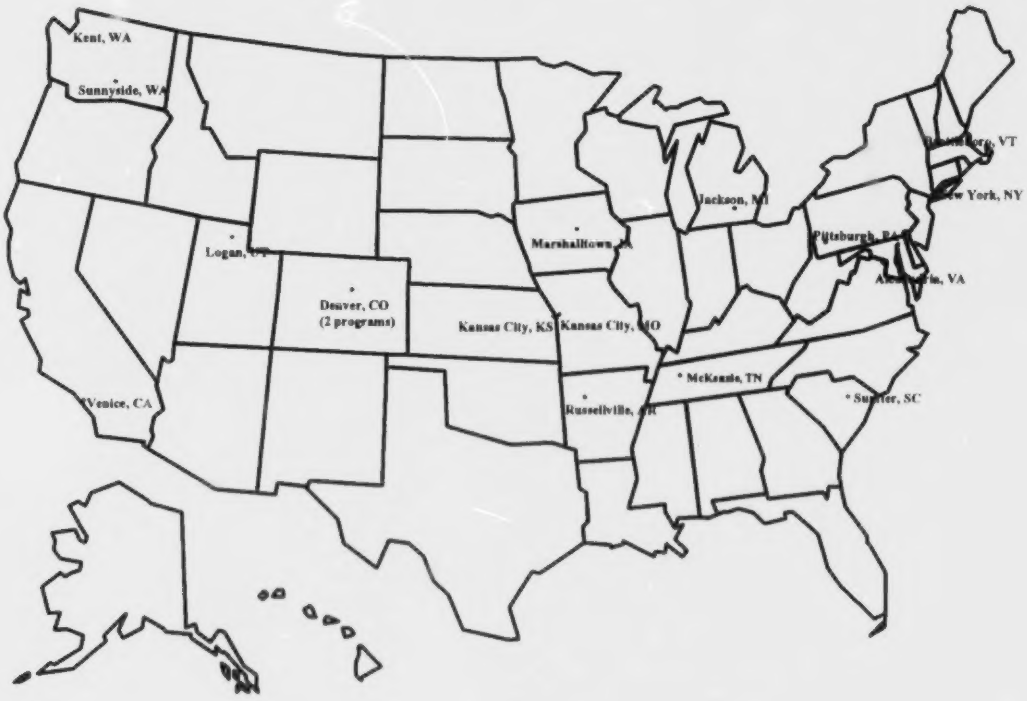
NOTE: Early Head Start programs may offer one or more options to families, including (1) a home-based option, (2) a center-based option, (3) a combination option in which families receive a prescribed number of home visits and center-based experiences, and (4) locally designed options. For purposes of the research, we have characterized programs according to the options they offer to families as follows:

--Center-based programs, which serve all families through the center-based option

--Home-based programs, which serve all families through the home-based option

--Mixed-approach programs, which serve some families through the center-based option and some families through the home-based option, or serve families through the combination option mid-Atlantic states (New York, Pennsylvania, Vermont, and Virginia). Three programs, all center-based, are in southern states (Arkansas, South Carolina, and Tennessee).

Early Head Start Research Programs


Kent, WA
Sunnyside, WA
Logan, UT
Denver, CO
(2 programs)
Kansas City, KS
Kansas City, MO
Marshalltown, IA
Jackson, MI
Brattleboro, VT
New York, NY
Pittsburgh, PA
Alexandria, VA
McKenzie, TN
Sumter, SC
Russellville, AR
Venice, CA

About half the Early Head Start research programs (eight) are in urban areas, and the other half are in small towns or rural areas (see Table II.1). Two programs have sites in both rural/small town and urban/suburban areas. Both the rural and the urban groups include a mix of home-based, center-based, and mixed-approach programs.

Some of the Early Head Start research programs provided services in more than one site. Most home-based programs were based in one central place, but two served several communities and had multiple offices. Most of the center-based and mixed-approach programs operated a number of

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centers. Three of the nine programs operated two centers, three operated three centers, and one operated six centers. The programs that operated three or more centers tended to be in rural areas and to serve families in more than one county.

The vitality of the economies varies in the areas the Early Head Start research programs served. Many of the programs operate in areas where the unemployment rate was five percent or higher in 1995, but seven programs are located where unemployment was lower. In four of the areas with relatively high unemployment rates, program staff members described job or job training opportunities as inadequate.

Although a few of the programs described their communities as "service-rich," all of them identified some areas in which services for low-income families were inadequate. All except one program reported that the supply of affordable high-quality child care in their community was inadequate to meet the demand, at least for infants, toddlers, and children with special needs. Many of the programs (13) indicated that their community lacked sufficient affordable housing, and most (10) also reported that public transportation was lacking or inadequate. Smaller numbers of programs noted that health care, mental health care, or dental services were inadequate. According to staff members in several of the programs, even where services are available, some families encounter barriers, such as lack of information about the services and how to get them, eligibility criteria that exclude the working poor, language barriers, unwillingness or inability to seek services because of the time and commitment required, mistrust or fear of the "system," fear of stigma, and lack of confidence and experience in seeking services. Lack of transportation also deters some families from seeking other available services.

B. CHARACTERISTICS OF FAMILIES ENROLLED IN THE RESEARCH PROGRAMS

Many of the research programs were still enrolling families at the time of the fall 1997 site visits, but by the end of 1998, all enrollment for the research was finished. The following sections provide a brief description of the enrolled families based on preliminary data from the Head Start Family Information System application and, for most of the families, enrollment forms.[1]

1. The Parents

Most of the primary caregivers who applied with their children to the Early Head Start research programs were female, but six percent were male (Table II.2). In every research program, at least 88 percent of primary caregivers were women.

Many primary caregivers, 40 percent overall, described their families as two-parent families. (Approximately one-fourth of the primary caregivers were married.) The extent to which the research programs served two-parent families varied widely. In five programs, more than half the families enrolled were two-parent families.

Many of the children's primary caregivers were teenage parents (about one-third across all the research programs). However, the extent to which the programs served teenage parents varied substantially, from 12 to 84 percent. In two programs, more than half of all families were headed by a teenage parent.

The racial/ethnic composition of enrolled families varied across the research programs. On average, about one-third of the families were African American, one-fourth were Hispanic, slightly more than one-third were white, and a small proportion belonged to other groups. In 11 programs, enrolled families belonged predominantly to one group. In four programs, at least two-thirds of families were African American; in two programs, at least two-thirds were Hispanic; and in five programs, at least two-thirds were white. In six programs, the racial/ethnic composition of enrolled families was diverse and not dominated by one group.

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[1] The data include all forms submitted to and processed by Mathematica Policy Research, Inc. (MPR) for program families by the end of March 1999. The data include information for 1,514 research sample families in the program group.

TABLE II.2

KEY CHARACTERISTICS OF FAMILIES ENTERING THE EARLY HEAD START RESEARCH PROGRAMS

	All Research Programs Combined (Percent)	Range Across Research Programs (Percent)
Primary Caregiver (Applicant) Is Female	94	88 to 99
Primary Caregiver Is a Teenager (under 20)	35	12 to 84
Primary Caregiver Is Married	28	2 to 70
Family is a Two-Parent Family	40	9 to 74
Primary Caregiver's Race/Ethnicity		
African American	33	0 to 89
Hispanic	24	0 to 89
White	37	2 to 91
Other	6	0 to 16
Primary Caregiver's Main Language Is Not English	21	0 to 81
Primary Caregiver Does Not Speak English Well	11	0 to 55
Primary Caregiver Lacks a High School Diploma	48	24 to 88
Primary Caregiver's Main Activity		
Employed	23	11 to 44
In school or training	22	4 to 64
Unemployed	29	13 to 43
Other	26	2 to 55
Number of Applicants/Programs	**1,514**	**17**

SOURCE: Preliminary Head Start Family Information System application and enrollment data.

Communication with families presented a challenge for some of the research programs. For a sizable minority of primary caregivers, English was not the main language. On average, 21 percent of primary caregivers did not speak English as their main language; 11 percent did not speak English well. In four programs, more than one-third of primary caregivers did not speak English as their main language. In two programs, more than half the primary caregivers did not speak English well.

The children's primary caregivers entered the research programs with varying levels of education. Overall, nearly half did not have a high school diploma. In three programs, more than two-thirds of the primary caregivers lacked one, while in four other programs, two-thirds of the caregivers had one.

Many of the primary caregivers in the Early Head Start research programs were employed or in school or training when they enrolled. On average, 23 percent were employed, and 22 percent were in school or training (usually school). In six of the research programs (four of which were center-based), more than half the caregivers were employed or in school or training, while in four other programs (all home-based or mixed-approach), fewer than one-third of the caregivers were employed or in school or training.

2. The Children

Most families enrolled before their child reached the age of 6 months.[2] Approximately one-fourth of the primary caregivers enrolled while they were still pregnant (Table II.3). Many additional families (42 percent, overall) enrolled after their child was born but before the child was 6 months old. The age distribution of children varied widely across the research programs. In three programs, more than three-fourths of the families enrolled before their child was 6 months old, while

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[2] To be eligible for the research, families had to be pregnant or have children under 1 year of age. Thus, all families for which data were available have children younger than age 1.

TABLE II.3

KEY CHARACTERISTICS OF CHILDREN ENTERING THE EARLY HEAD START RESEARCH PROGRAMS

	All Research Programs Combined (Percent)	Range Across Research Programs (Percent)
Child's Age		
Unborn	25	7 to 67
0 to 6 months old	42	12 to 57
6 to 12 months old	33	1 to 75
Child Was Born at Low Birthweight (Under 2,500 grams)	10	4 to 23
Concerns About Child's Development Were Noted on Application Form	13	3 to 26
Number of Applicants/Programs	**1,514**	**17**

SOURCE: Preliminary Head Start Family Information System application and enrollment data.

in another program, fewer than one-third of the families did.

Among the children who were born before their family enrolled, 10 percent had a low birthweight (under 2,500 grams). This, too, varied across the research programs, from 4 to 23 percent. Similarly, when they applied to Early Head Start, 13 percent of the primary caregivers reported that they or someone else had a concern about their child's development. Across the research programs, the extent of concerns ranged from 3 to 26 percent.

Together, these indicators suggest that 20 percent of the children who were enrolled in the Early Head Start research programs after birth might have had or were at risk for a developmental disability.[3] Four percent of the children who were enrolled after birth had been born at a low birthweight, and concerns about their development were reported in the application form. Nine percent of the children had not been born at a low birthweight, but their primary caregivers reported that someone had a concern about their development. Seven percent had been born at a low birthweight, but their primary caregiver did not report that someone had a concern about their development.

3. Basic Needs and Receipt of Public Assistance

Some of the families had basic needs that were not being met when they enrolled in the research programs. Overall, 5 percent reported that they did not have adequate food, and 12 to 14 percent did not have adequate housing, medical care, or personal support (Table II.4). Approximately 13 percent also indicated that they did not have adequate parenting information.

A substantial unmet need for child care was expressed by the primary caregivers who enrolled in the research programs. Overall, 35 percent of the primary caregivers did not have adequate child

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[3] Better information about children's disabilities will be available from later rounds of data collection conducted when children are older.

TABLE II.4

FAMILY RESOURCES AND RECEIPT OF ASSISTANCE BY FAMILIES ENTERING THE EARLY HEAD START RESEARCH PROGRAMS

	All Research Programs Combined (Percent)	Range Across Research Programs (Percent)
Adequacy of Resources		
Inadequate food	5	0 to 20
Inadequate housing	12	4 to 24
Inadequate medical care	14	3 to 36
Inadequate child care	35	11 to 67
Inadequate transportation	21	12 to 35
Inadequate parenting information	13	0 to 39
Inadequate personal support	13	3 to 39
Assistance Received Currently		
Medicaid	77	47 to 89
AFDC/TANF	34	11 to 64
Food stamps	48	22 to 75
WIC	87	69 to 96
SSI	7	0 to 16
Number of Applicants/Programs	**1,514**	**17**

SOURCE: Preliminary Head Start Family Information System application and enrollment data.

care arrangements when they enrolled. Unmet child care needs varied across the research programs, however. In four programs, at least half the families had unmet child care needs, while in three other programs, fewer than 15 percent had them.

Many primary caregivers also reported that they did not have adequate transportation. Overall, 21 percent of the primary caregivers did not have adequate transportation when they enrolled in the research programs. Unmet transportation needs varied across research programs, ranging from 12 to 35 percent.

Most of the families who enrolled in the research programs were receiving some kind of public assistance. Overall, 77 percent were receiving Medicaid coverage, and 87 percent were receiving WIC benefits. Almost half the families were receiving food stamps, and slightly more than one-third were receiving AFDC or TANF cash assistance (some mothers were pregnant with their first child when they enrolled and were not yet eligible for cash assistance). A small proportion (seven percent) were receiving SSI benefits. As in other areas, the extent to which families were receiving assistance varied across the research programs. In all the programs, however, many families were relying on these sources of assistance.

C. SIMILARITY OF THE RESEARCH PROGRAMS TO ALL EARLY HEAD START PROGRAMS

ACYF selected 15 of the 17 research programs from among the 41 Wave I Early Head Start programs that applied with a university partner to conduct local research and participate in the national cross-site evaluation. The university partners agreed to conduct data collection for the national evaluation under subcontract to MPR and to form a consortium with the other local researchers and MPR to ensure that all parts of the study form a cohesive whole. As noted in Chapter I, the 15 programs were selected to include a balanced distribution of sites by program approach, program history, geographic location (regions and urban/rural locations), and racial/ethnic composition of families in the target population.

Because the final selection of 15 research programs included a disproportionately low number of center-based programs, ACYF added two center-based programs to the national research. In selecting them, ACYF also sought to bring further balance by adding a center-based program that would serve predominantly African American families and one that had not operated as part of CCDP. One of the added research programs was funded in Wave II of Early Head Start programs.

The final selection of 17 research programs constitutes a balanced group that includes variation in the key characteristics considered in the site-selection process. All approaches, backgrounds, regions, urban/rural areas, and racial/ethnic makeups are represented among the research programs (see Table II.1). This variation will facilitate the cross-site evaluation's investigation of what program approaches work for whom and under what circumstances.

Not only were the programs that ACYF selected for the cross-site research balanced, they broadly resembled all Wave I and Wave II Early Head Start programs. Comparisons of available Program Information Report (PIR) data for Wave I and II programs with Head Start Family Information System data for the research programs indicate that the two groups of programs are very similar. They have approximately the same ACYF-funded enrollment, on average, and the characteristics of enrolled children and families are very much alike (Table II.5). Because the research sites closely resemble the Wave I and II programs in both program and family characteristics, lessons learned from these programs are likely to be applicable to other Early Head Start programs.

TABLE II.5

COMPARISON OF RESEARCH PROGRAMS AND WAVE I AND II PROGRAMS

	Wave I Programs (Percent)	Wave II Programs (Percent)	Research Programs (Percent)
Total ACYF-Funded Enrollment			
10 to 29 children	6	0	0[a]
30 to 59 children	14	9	6
60 to 98 children	62	64	65
100 to 199 children	15	27	29
200 to 299 children	3	0	0
(Average)	(81)	(84)	(85)
Race/Ethnicity of Enrolled Children			
African American	33	21	34[a]
Hispanic	22	27	23
White	39	46	37
Other	6	5	6
English Is the Main Language	85	79	80
Family Type			
Two-parent families	39	46	40
Single-parent families	51	46	52
Other relatives[b]	7	5	3
Foster families	1	1	0
Other	1	1	5
Employment Status[c]			
In school or training	20	22	22
Not employed	48	48	56
Number of Programs	**66**	**11**	**17**

SOURCE: Preliminary Head Start Family Information System application and enrollment data.

NOTE: The percentages for the Wave I and II Early Head Start programs are derived from available Program Information Report (PIR) data. The percentages for the Early Head Start research programs are derived from preliminary Head Start Family Information System application and enrollment data from 1,462 families.

Percentages may not add up to 100, as a result of rounding.

[a] The data for the research programs refer to families instead of children.

[b] The HSFIS data elements and definitions manual instructs programs to mark "other relatives" if the child is being raised by relatives other than his/her parents, such as grandparents, aunts, or uncles, but not if the child is being raised by his/her parents, and is living with other relatives as well.

[c] The research program data and PIR data are not consistent in the way that they count primary caregivers' employment status, so it is not possible to compare the percentage of caregivers who are employed.

D. PROGRAM THEORIES OF CHANGE

As we have seen, Early Head Start programs have adopted a variety of program approaches and taken a variety of shapes. The evaluation must be able to describe and understand this program diversity, not only for descriptive purposes, but also to enable researchers to ascribe impact findings to the important experiences of the children and families enrolled. In recent years, an approach to understanding programs' intended outcomes and strategies for achieving them has emerged in the program evaluation literature. Sometimes referred to as a "logic model" (for example, Harrell 1996) or a "theory-of-change" approach (Berlin, O'Neal, and Brooks-Gunn 1998; Chen and Rossi 1992; Connell and Kubisch 1998; Hebert and Anderson 1998; Kagan 1998; Mulligan et al. 1998; and Weiss 1972 and 1995), this approach allows program evaluators, in collaboration with program staff, to go through a systematic process of (1) identifying specific outcomes the program expects to achieve; (2) articulating the program strategies and activities that are designed to achieve the outcomes, as well as the context in which the strategies and activities occur; (3) selecting measures appropriate for assessing the outcomes; and (4) planning analyses that will focus on the outcomes of importance to the program. In this section, we focus on the *outcomes* to illustrate both commonalities and differences in the expected achievements identified by the Early Head Start research programs in their early stages.

Unfortunately, the history of program evaluation is replete with examples of evaluators assuming, without verifying, that all programs sharing the same label (whether "Even Start," "Comprehensive Child Development Program," "Early Head Start," or even "child care" or "home-based programs") have the same objectives and intentions and are engaged in the same activities. Although programs that are part of the same national initiative share broad goals, they often adopt a range of different specific goals and take diverse approaches to achieving them. Policymakers too often are presented with evaluation findings that appear not to have captured these variations in programs' specific goals and approaches, so they have little value for guiding policy changes. In Early Head Start, programs share the broad goal of promoting the healthy development of young children and their families, and they must adhere to basic program guidelines and the revised Head Start Program Performance Standards. Within these broad guidelines, however, Early Head Start programs have the flexibility to customize their goals and approaches to fit the circumstances, needs, and resources of their local communities. By using a theory-of-change approach in the Early Head Start evaluation, we are identifying the variations across Early Head Start research programs in their specific goals, approaches, and expected outcomes and planning targeted impact analyses that close the circle between the programs' intentions and their outcomes.

The benefits of working with programs' theories of change come only after substantial effort. Kagan (1998), for example, noted the extensive nature of this effort in connection with family support programs. As part of the Early Head Start evaluation, the national evaluation team began the theory-of-change process in 1996 at meetings of the Early Head Start Research Consortium, with discussions that engaged both local researchers and program directors from the research sites. In many sites, discussions between local research and program staffs continued, resulting in increasingly sophisticated iterations of programs' theories of change; many of these programs produced documents detailing the process and the resulting theories of change. During MPR's site visits in fall 1997, site visitors discussed theories of change with program staff and usually included one or more representatives from the local research team. Site visitors followed a common group interview guide and asked the following types of questions with respect to outcomes:

1. Considering *all* your goals and *all* the outcomes your program is trying to influence, which two or three are you focusing most intensively on? Which are your highest priorities? Why?

2. Are these the outcomes you think you are most likely to influence? Why or why not? If not, what outcomes do you think you will be able to influence the most? I know you think you will influence many outcomes, but if you were going to place bets on two or three outcomes that you think you will influence most, which would you choose?

Then, for each of the key outcome areas--child development, family development, staff development, and community-building--we asked a series of questions designed to bring out specific details in each of the outcome areas.

The evaluation team also tried to understand strategies for attaining outcomes and the extent to which program staff saw factors outside the program as affecting the program's ability to achieve the outcomes they described. Program staff described factors as diverse as the (as yet uncertain) influence of welfare reform, the availability and quality of child care or other services in the community, the strong presence of a local church, or the closing of a housing project.

Through this approach, we obtained the information firsthand without having to rely on written communication alone (although in a number of cases program staff and/or local researchers provided the site visitor with written materials from their previous discussions about their theories of change). By engaging program staff members in similar discussions across all sites and allowing them to elaborate on particular elements of their theories of change, the evaluation team was able to compare information obtained through a relatively uniform process. Thus, we obtained a fuller sense of the nuances of programs' theories of change than we would have had our analysis been limited to written documents.

On the other hand, we acknowledge that this approach contained variability. Usually, the program staff who participated represented diverse roles (program directors, supervisors, specialists, and frontline staff such as home visitors or center caregivers), but there were also site differences in the mix of staff. Furthermore, the amount of time spent varied according to the availability of staff and the time spent on other site-visit interviews. When the time was shorter than planned, some of the areas were not covered as thoroughly as we had hoped. The sessions began with an open-ended discussion of the program's most important goals followed by a focus on each key area, beginning with child and family development. Therefore, the areas most likely to be slighted by this process were staff development and community building. Although the information about outcomes in those areas is not as rich as in the child and family development areas, the process resulted in the most complete information in the areas that are most central to Early Head Start program goals.

After the site visits, at a meeting of program directors and researchers held in spring 1998, we asked program directors to (1) indicate all outcomes across all the program areas that were "important" goals for their program and (2) identify the three important outcomes that were the "highest priority" for their program, regardless of the area the outcomes were in. In addition, we asked program directors attending the meeting to "tell a success story." We asked them to think of a family that exemplified the success their program had had so far (as of spring 1998) and to describe in some detail the experiences of the children and family and the outcomes the children and family achieved. The sections that follow report on the results of both our theory-of-change discussions in fall 1997 and program directors' ranking of outcomes in spring 1998. We also use information from the success stories to illustrate or expand on the theory-of-change information obtained from the interviews.

The results of the theory-of-change discussion described here are the first installment in a dynamic, ongoing process. Since spring 1998, local researchers and program staff in many sites have continued their theory-of-change discussions. During the summer/fall 1999 site visits, the national evaluation team engaged program staff in additional discussions, and the second implementation study report will present an analysis of the then-current Early Head Start programs' intended outcomes within the context of their theories of change, and how they evolved over time.

1. Articulation of Programs' Expected Outcomes

Several general features of programs' expected outcomes (as articulated through our process) are worth noting before presenting the specific findings. One is that all programs were able to articulate a number of critical aspects of their expected outcomes. Typically, several staff within a program had considered, often in discussions with their local research partners, their expected outcomes and how they hoped to achieve them. This occurred at different levels of detail and breadth: some had worked closely with their local researchers, others not so closely, a few not at all. Staff identified outcomes they considered important in all four areas, as well as in parent-child relationships, which we added as a fifth area since it overlaps the child and family areas and includes outcomes that program staff and researchers alike were reluctant to place into either the child or the family category.

We found that program staff members tended to think about outcomes in broad, rather than focused and specific, terms. Thus, they might tell us about "improving children's social competence" rather than "enhancing peer interactions" or "reducing aggressiveness." Staff often had difficulty getting beyond process to think about outcomes. Thus, they might report that "families will participate in more group socializations" or "families will succeed in attaining a medical home." Site visitors took these as implicit theory-of-change statements and probed to learn what particular outcome or outcomes program staff believed that participation would bring about. Staff members sometimes had difficulty identifying the most important outcomes, because they are well aware of the great variation in where families start out, what their different needs are, how long they have been engaged in program activities, and so forth.

2. Outcomes Expected Across Program Areas

There was considerable diversity in both the type and the number of outcomes that individual programs described. Table II.6 summarizes the major types of outcomes that each research program

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TABLE II.6

OVERVIEW OF KEY OUTCOMES IDENTIFIED IN PROGRAMS' THEORIES OF CHANGE WITHIN EACH DOMAIN[a]

Programs[b]	Parent-Child Relationships	Child Development	Family Development	Staff Development [c]	Community Building [c]
Center-Based Programs					
A	*Parental knowledge of child development* Attachment, knowledge of child development, and understanding the parent-child relationship	*Cognitive development* Cognitive, language, social-emotional, physical, approaches toward learning, and school readiness	Physical health, mental health and healthy family functioning, self-sufficiency, literacy and education, and home environment	*Improved staff competencies* Staff competencies and community involvement	Quality of community child care, quality of other community services, coordination of services and collaboration, and involvement of parents in the community
B	*Parent-child relationships* Attachment and knowledge of child development	Cognitive, social-emotional, physical, and school readiness	*Mental health* Physical health, mental health and healthy family functioning, self-sufficiency, and home environment	*Staff self-esteem* Staff competencies	Quality of community child care and involvement of parents in the community
C	*Parent-child relationships* Attachment and knowledge of child development	Cognitive, social-emotional, physical, approaches toward learning, and readiness for Head Start	*Self-efficacy* mental health and healthy family functioning, self-sufficiency, and literacy and education	*Improved staff competencies* Staff competencies and career development	Involvement of parents in the community
D	*Parent-child relationships* Knowledge of child development	Cognitive, social-emotional, approaches toward learning, and school readiness	*Economic self-sufficiency/employment* Self-sufficiency and home environment	*Improved staff competencies* Staff competencies and teamwork and morale	Involvement of parents in the community
Home-Based Programs					
E	*Parental knowledge of child development* Attachment, knowledge of child development, and understanding the parent-child relationship	*Cognitive development* Social-emotional and approaches toward learning	*Family goal setting* Mental health and healthy family functioning, self-sufficiency, and home environment	Staff development not discussed during site visit	Community cornerstone not discussed during site visit
F	Understanding the parent-child relationship	*Language development* Cognitive, social-emotional, and physical	*Literacy/education* Mental health and healthy family functioning, self-sufficiency, literacy and education, and home environment	Staff competencies and teamwork and morale	*Improved quality of community child care* Involvement of parents in the community
G	*Parent-child relationships* *Parenting stress* Attachment, knowledge of child development, and understanding the parent-child relationship	Cognitive, language, social-emotional, and approaches toward learning	Mental health and healthy family functioning, self-sufficiency, and father involvement	*Improved staff competencies* Staff competencies, teamwork and morale, career development, and community involvement	Quality of community child care, and coordination of services and collaboration

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TABLE II.6 *(continued)*

Programs[b]	Parent-Child Relationships	Child Development	Family Development	Staff Development[c]	Community Building[c]
H	*Parent-child relationships* *Parental knowledge of child development* Attachment, knowledge of child development, and parenting	Language, social-emotional, physical, approaches toward learning, and school readiness	Self-sufficiency, home environment, and father involvement	*Improved staff competencies* Staff competencies, teamwork and morale, and career development	Quality of community child care, quality of other community services, coordination of services and collaboration, and involvement of parents in the community
I	Attachment, knowledge of child development, understanding the parent-child relationship, and parenting	*Cognitive development* *Language development* *Social development* Social-emotional and physical	Physical health, mental health and healthy family functioning, self-sufficiency, and home environment	Staff development not discussed during site visit	Quality of community child care, quality of other community services, coordination of services and collaboration, and involvement of parents in the community
J	*Parent-child relationships* Knowledge of child development, understanding the parent-child relationship, and parenting	Cognitive, social-emotional, physical, and approaches toward learning	*Literacy/education* Physical health, mental health and healthy family functioning, self-sufficiency, literacy and education, and home environment	Staff competencies and career development	*Quality of community child care* Quality of community child care, quality of other community services, coordination of services and collaboration, and involvement of parents in the community
K	*Parenting confidence and competence* *Parent-child relationships* Knowledge of child development and parenting	*Social-emotional development* Cognitive, language, social-emotional, physical, and approaches toward learning	Self-sufficiency and home environment	Staff competencies	Quality of community child care and involvement of parents in the community
L	*Parent-child relationships* *Parental knowledge of child development* Attachment, knowledge of child development, understanding the parent-child relationship, and parenting	*Physical development/health* Cognitive, social-emotional, physical, and school readiness	Physical health, mental health and healthy family functioning, self-sufficiency, literacy and education, and father involvement	Staff competencies, teamwork and morale, and career development	Quality of community child care, quality of other community services, and involvement of parents in the community

TABLE II.6 *(continued)*

Programs[b]	Parent-Child Relationships	Child Development	Family Development	Staff Development[c]	Community Building[c]
Mixed-Approach Programs					
M	*Parent-child relationships* Attachment, knowledge of child development, and understanding the parent-child relationship	Social-emotional and approaches toward learning	*Economic self-sufficiency/employment* Mental health and healthy family functioning	Staff development not discussed during site visit	*Quality of community child care* Involvement of parents in the community
N	Knowledge of child development and parenting	*Language development* Language, social-emotional, physical, approaches toward learning, and knowledge of their community and its diversity	*Economic self-sufficiency/employment* Mental health and healthy family functioning, self-sufficiency, home environment, and father involvement	Teamwork and morale and career development	*Coordination of services* Quality of community child care
O	*Parenting stress* Knowledge of child development and parenting	*Physical development and health* Cognitive, language, social-emotional, physical, and approaches toward learning	Physical health, mental health and healthy family functioning, self-sufficiency, and home environment	Staff competencies and career development	*Collaboration* Quality of other community services, coordination of services and collaboration, and involvement of parents in the community
P	Attachment, knowledge of child development, and parenting	*Language development* *Social development* Cognitive, language, social-emotional, and physical	Physical health, mental health and healthy family functioning, self-sufficiency, and home environment	Staff competencies, teamwork and morale, and career development	*Quality of community child care* Quality of community child care, coordination of services and collaboration, and involvement of parents in the community
Q	*Parent-child relationships* *Parental knowledge of child development* Attachment, knowledge of child development, and parenting	Social-emotional and physical	Mental health and healthy family functioning and self-sufficiency	Teamwork and morale	*Quality of community child care* Quality of other community services, coordination of services and collaboration, and involvement of parents in the community

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[a] The entries under each domain indicate the key areas in which each program indicated important outcomes in the theory-of-change discussions during the fall 1997 site visits. The outcomes highlighted in italics are the programs' "priority" outcomes (see text) as identified in May 1998.

[b] The programs are listed in random order within categories of programs by major approach.

[c] Because of time constraints, this domain was not discussed during some site visits.

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cited during sites visits, organized by area, with their priority outcomes italicized (programs were not limited in the number of outcomes they could identify). Because our focus here is on understanding the range, diversity, and similarities across Early Head Start research programs, we do not identify the individual programs.

Even though the national Head Start Bureau has been clear that child outcomes are the most important program goals, we begin our discussion with parent-child relationships because of their special importance during infancy and because a number of program staff felt that secure attachment in the parent-child relationship establishes the foundation for enhanced development of children. We then discuss programs' expected outcomes in child development, family development, staff development, and community development.

Both in programs' descriptions of their expected outcomes and in our analysis of these descriptions, we find that boundaries around the key program areas can be drawn in more than one way. For example, one reason we treat parent-child relationships separately is that we find considerable overlap with both the child and the family development areas. In the presentation that follows, there remain some topics that could be categorized differently. For example, we discuss the home environment within the family development area, because it is a broad category that encompasses aspects of the context in which children live, even though some elements of the home environment might well be placed under parent-child relationships. The categorization presented here is based on program staff members' responses to the questions about key expected outcomes in each key program area and thus largely reflects their own perception of outcomes.

Parent-Child Relationships. Table II.7 displays the outcomes that program staff identified as important in parent-child relationships. Early Head Start research programs viewed enhancing parent-child relationships and parenting as central to their mission. Within this area, however, considerable diversity characterizes the specific outcomes that programs were trying to accomplish.

TABLE II.7

KEY PARENT-CHILD RELATIONSHIP OUTCOMES IDENTIFIED BY PROGRAMS

- Secure attachment
- Understanding the nature of the parent-child relationship
- Seeing the importance of the relationship for the child's future development
- Knowledge of child development
- Developing respect for the child
- Reducing the stress of parenting
- Developing good parenting skills

One of the most important outcomes within parent-child relationships is a secure parent-child attachment. Program staff expressed this in various ways, such as infants becoming more securely attached to their mothers, "bonding," and developing a strong relationship with the parent. Some behavioral indexes of secure attachment included mothers learning to "read" their children's cues and establishing "reciprocity of attachment." "Understanding the nature of the parent-child relationship" is another identified outcome that is closely associated with the attachment concept, and some programs had a particular interest in helping parents see the importance of the relationship for the child's future development. Many program staff were more general and talked about their goal of developing parent-child relationships that were "more positive."

Another aspect of parent-child relationships involves what parents know and understand about children. Specifically, staff in all but one of the programs said that increased knowledge of child development was an important outcome for their parents. Programs hoped parents would understand "normal" development, gain accurate knowledge of children's capabilities at different stages of development, and also recognize individual differences across children. Many staff told us they hoped this would appear as more appropriate and realistic expectations for children's behavior. In one site, knowledge of child development extended to developing understanding and tolerance for children's feelings. One program cited a special emphasis on developing the parental knowledge and skills needed to care for infants and toddlers with disabilities, while another cited knowledge of children's nutritional needs. At another site, helping parents develop respect for their children was an important aim of program staff. In one program, staff added an interest in parents being able to use their knowledge of child development to help them choose quality child care.

Aspects of improved parenting were mentioned often in our theory-of-change discussions. The specific features of parenting were quite diverse, including reducing the stress of parenting (that is, making healthier choices), being the "first teacher" of the child, using positive discipline techniques, empathic listening, being involved in more activities conducive to child development, having greater confidence in parenting, displaying less negativity, showing "resilience by use of appropriate techniques for handling stress and conflict," and, as staff at several sites mentioned, reducing the incidence of abuse and neglect.

In summary, almost all programs emphasized knowledge of child development, and a substantial percentage focused on supporting parent-child attachment. Most programs saw parent-child relationships as key to enhancing children's development.

Child Development. Programs identified a large number of outcomes in the child development arena, as is consistent with the national program focus. We organized them into five dimensions of children's development and learning, as shown in Table II.8.

To arrive at these five dimensions, we sorted all the child outcomes that program staff identified in our interviews into standard categories typically used by developmental psychologists. In particular, we consulted the classification system developed by the Goal One Technical Planning Group of the National Education Goals Panel (Kagan, Moore, and Bredekamp 1995), which articulated five dimensions of children's early development and learning similar to the ones we present in Table II.8. These dimensions closely parallel those identified in the Head Start Program Performance Measures, which include six "performance measures" under the objective of enhancing children's growth and development.[4] It is especially noteworthy that a number of expected Early Head Start outcomes are highly consistent with an area referred to as "approaches toward learning" (Kagan et al. 1995) or "positive attitudes toward learning" (Administration on Children, Youth and Families 1998), which includes constructs that are not easily classified as cognitive or

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[4] The six Head Start Performance Measures include (1) emergent literacy, numeracy, and language skills; (2) general cognitive skills; (3) gross and fine motor skills; (4) positive attitudes toward learning; (5) social behavior and emotional well-being; and (6) physical health (Administration on Children, Youth and Families 1998; McKey, Tarullo, & Doan 1999).

TABLE II.8

KEY CHILD DEVELOPMENT OUTCOMES IDENTIFIED BY PROGRAMS

Cognitive Development	Language Development
• Improved problem-solving skills	• Increased communication skills
• More ready to learn	• Better able to communicate in a bilingual environment
• Better prepared for reading	• Emerging literacy skills
• Fewer developmental delays	• Larger vocabulary

Social-Emotional Development	Approaches Toward Learning
• Increased spontaneity	• More engaged with environment
• More positive attitudes and feelings about school	• Greater self-regulation, self-control
	• Improved task orientation, concentration
• Enhanced emotional well-being	• More confident, wanting to explore
• Sustain healthy relationships with peers	• Greater curiosity
• Less fear, anxiety, depression	• Enhanced independence, self-help skills
• More secure and relaxed	• Better able to deal with school

Physical Development, Health, and Safety	
• Better nutrition	• Fewer accidents
• Healthier	• Mobility commensurate with abilities
• Improved motor development	• Fewer low-birthweight babies

social-emotional, but often have elements of both and are seen as particularly critical elements of school readiness. It is also noteworthy that programs think well beyond the narrow cognitive or "IQ" outcomes that some past intervention programs have focused on.

Every one of the programs identified child outcomes across multiple dimensions. The two dimensions in which programs mentioned the most outcomes were social-emotional development and physical development, health, and safety. Social-emotional development is the only dimension in this area that all 17 programs mentioned specifically during the site visits. Table II.8 indicates some of the most common aspects of child development that the programs identified. The table shows considerable diversity in the aspects of physical development, health, and safety that program staff valued. Many of the programs identified cognitive and language outcomes as ones they were expecting to achieve with Early Head Start infants and toddlers, as well as outcomes that we classified as "approaches toward learning." These latter range from "greater self-regulation and self-control" to "more confident, wanting to explore" to "greater curiosity."

A look at the child development outcomes overall reveals that the Early Head Start research programs are striving to achieve outcomes for infants and toddlers that will benefit the children as they transition into preschool and school programs. About half the programs explicitly named "school readiness" as an ultimate goal of their program activities, although several made it clear to us that they took an indirect or holistic approach to readiness, cognitive growth, and language development, meaning that these outcomes would be a byproduct of a supportive environment rather than the direct result of a focus on child development activities.

Family Development. With parent-child relationships considered as a separate area, the major dimensions of this area are the home environment and parental self-sufficiency. In addition, programs identified family development outcomes in areas that we describe as parental mental health and healthy family functioning; family physical health, health care, and safety; parent literacy and education; and father involvement. Table II.9 shows the specific expected outcomes that program staff identified within each dimension.

"Home environment," specially identified by three-fourths of the programs, is a broad area in which programs work to achieve a wide range of outcomes relating to enhancing the immediate surroundings in which Early Head Start infants and toddlers grow up. In contrast to the outcomes described under parent-child relationships, home environment outcomes describe features of the context in which children live. While these outcomes may affect parent-child relationships, they are broader and more oriented toward characterizing what might be thought of as a healthy environment for children's current well-being and future growth. Programs are striving to improve a number of factors that are likely to enhance child development, whether that means reducing frustration, child abuse, and domestic violence, or increasing parental responsibility for children's learning and age-appropriate play between parent and child.

Parental mental health and healthy family functioning were important to many programs and were mentioned in our interviews by the majority of the programs. We clustered into this area a number of outcomes the programs cited, including global expectations like "creating a more positive outlook on life" and "developing healthier lifestyles" and specific goals like "improved self-esteem" and "greater family stability." The area of physical health, health care, and safety includes both outcomes for parents and outcomes that parents are expected to help achieve (or to mediate) for families. Outcomes for parents include increased knowledge of sexuality, sexually transmitted diseases, prenatal care, and nutrition. Specifically, parents are expected to meet family members' physical needs and take a proactive approach to obtaining appropriate health care for their children.

Self-sufficiency outcomes demonstrate the important goals that programs had for the parents themselves. All but one of the Early Head Start research programs described expected outcomes in this area. The common theme of the specific outcomes identified is that programs are engaged

TABLE II.9

KEY FAMILY DEVELOPMENT OUTCOMES IDENTIFIED BY PROGRAMS

Home Environment for Children

- Create a stimulating home environment
- Apply Montessori concepts in the home
- Reduce domestic violence
- Increase age-appropriate play between parent and child
- Include infants and toddlers with disabilities in daily activities in the home and community
- Encourage parents to take responsibility for children's learning and development
- Reduce frustration and child abuse in the home
- Liberate parents to enjoy their children

Parental Self-Sufficiency

- Knows about resources and becomes able to do things independently
- Motivated to improve standard of living
- Understands requirements of the welfare system
- Knows how to access services
- Sets goals for self and moves toward them on own initiative
- Knows ways to plan and have choices
- Is able to make sound decisions for the family
- Is self-confident, able to advocate on behalf of self and family
- Is empowered
- Achieves economic self-sufficiency
- Understands the work ethic
- Has confidence, knowledge, and skill to identify barriers and resources, and act independently to achieve own goals

Parental Mental Health and Healthy Family Functioning

- Increased parental social skills
- Improved parental self-esteem, pride, and confidence
- Create more stable homes; maintain intact families
- Create positive, strong, and healthy relationships within the family
- Increase family members' mutual enjoyment
- Increased conflict-resolution skills, ability to deal with feelings, anger management
- Create in parents a more positive outlook on life
- Create a world view and sense of self
- Healthier lifestyles
- Better able to meet emotional needs of family members
- Maintain family systems that support open and warm communication, respect, and support for family members

Physical Health, Health Care, and Safety

- Better able to meet the basic physical needs of family members
- Be more proactive about children's health care
- Able to obtain preventive and emergent medical care, including prenatal care
- Increased parental knowledge of their own bodies
- Increased knowledge of sexuality and sexually transmitted diseases
- More knowledge of prenatal care
- Increased use of car seat for infant/toddler
- Increased skills in preparing nutritious meals

TABLE II.9 *(continued)*

Parent Literacy and Education	Father Involvement
• Attend school and further their own education	• Improved father-child relationships
• Develop both English and Spanish literacy	• Encourage fathers to be good role models for their children
• Achieve adult basic education skills	• Increase father involvement in the family
	• Change fathers' attitudes toward their role as fathers

in activities designed to enhance the parents' ability to be self-reliant and to achieve personal and family goals with increasing degrees of independence from the program. Goals in the area of literacy and education overlap a great deal with self-sufficiency goals, but we list them separately because of their significance for a number of programs.

Finally, our discussions of the family development area elicited discussion of intended outcomes for the fathers of Early Head Start children. Although we did not obtain extensive details in fall 1997, it is clear that a number of programs were increasingly emphasizing efforts to enhance father-child relationships and expand fathers' involvement with their families. As part of the fatherhood research within Early Head Start, both local and national studies will be learning more about program activities aimed at increasing father involvement in families and programs.

In summary, Early Head Start research programs had a great deal in common in their expected family development outcomes. In particular, most indicated a strong focus on enhancing aspects of the home environment, increasing parental self-sufficiency, and improving parental mental health and healthy family functioning; some programs emphasized physical health and safety and parental literacy and education.

Staff Development. Staff development was seen as important both for the sake of effective program operations and for the ultimate benefit that more skillful, satisfied, and stable staff may have on the children and families they work with. Twelve of the 14 programs that we discussed this area with identified staff competencies as important outcomes.[5] The range of intended outcomes shown in Table II.10 emphasizes programs' concerns with knowledge and skills that will directly affect staff members' ability to do their jobs. These outcomes indicate that programs saw staff as integral to achieving outcomes in all other areas, since the knowledge and skills desired for their staff

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[5] As noted in Table II.6, site visit schedules sometimes resulted in insufficient discussion of staff development outcomes for us to be able to summarize the program's expected outcomes in this area.

TABLE II.10

KEY STAFF DEVELOPMENT OUTCOMES IDENTIFIED BY PROGRAMS

- Increased knowledge of child development
- Increased knowledge of parenting
- Improved observational skills
- Know more about their community and be more involved in their community
- Respect for families' culture
- Improved communication with families
- Build trusting relationships with parents
- Improved teamwork and morale
- Skill in relationship building--with children, families, community
- Collaborative skills in working with other service providers
- Knowledge about inclusion of infants and toddlers with disabilities
- Career development

relate to child development, family development, and the community.

Community Building. The focus of programs' theories of change in this area was clearly associated with one of the major Early Head Start goals as stated in the Early Head Start program guidelines--to increase access to high-quality services, including child care, for program families and to encourage systemic improvements in service delivery for all families in the community. Table II.11 lists the major aspects of community change that program staff told us about.

These outcomes indicate that programs were aware of the complexity of their community-building objectives. They show recognition that parents, staff, and community agencies are all important if changes in child care are to come about, and that programs valued thinking in terms of systems change as opposed to relying on piecemeal efforts. Some programs indicated ambitious goals, such as making all systems that affect children in their community (churches, schools, police, and courts) more sensitive to the needs of children and families. Several noted that they were trying to increase the number of formal and informal agreements with other agencies so they would strengthen their collaborations and community partnerships. A theme common to several programs was an emphasis on the role of parents--most of the programs we discussed this area with mentioned increasing parents' involvement in the community, encouraging them to be advocates for themselves and their children, and helping them become mentors or models for other parents in the community.

3. The Perspective of Prioritized Outcomes

In spring 1998, we asked directors of the research programs to reflect on their theories of change and, first, to identify all the outcomes they considered "important," and then to select the three most important outcomes--those with the highest priority--regardless of the area they were in. While acknowledging that this was a difficult and somewhat artificial task, we introduced this task as a way of bringing to light what might otherwise remain implicit emphases of the programs.

TABLE II.11

KEY COMMUNITY OUTCOMES IDENTIFIED BY PROGRAMS

- Deliver program and staff development services to family child care providers
- Cooperate with county agencies to develop high-quality child care
- Enhance coordination of services and collaboration
- Create systems change through provider training
- Involve Early Head Start parents in the community
- Parents will understand and value quality in child care
- Improve quality of other community services

We made it clear to the programs, and we want to emphasize here, that programs find many outcomes beyond these to be important, as the details in the preceding section indicate. Nevertheless, programs' identification of priority outcomes provides additional understanding of their intentions. All programs identified at least one priority outcome in either the child development or parent-child relationships area. Our analysis, however, takes the perspective of all the outcomes and asks, "what are the types and range of outcomes that Early Head Start research programs as a whole see as priority?" The percentages of priority outcomes identified in each area were as follows:

- Parent-child relationships: 37 percent
- Child development: 22 percent
- Family development: 16 percent
- Community building: 14 percent
- Staff development: 12 percent

When parent-child relationships and child development outcomes are grouped together (which is reasonable given that programs' central purpose in focusing on the parent-child relationship during the infant-toddler period was to enhance children's development), this combined area encompasses 59 percent of all the priority outcomes.

Two aspects of the priority outcomes were shared by all three program approaches:

- All three program approaches identified one-third or more of their priority outcomes in parent-child relationships.
- All three program approaches identified one-fourth or fewer of their priority outcomes in the family development area.

In addition, programs with different approaches reported somewhat different priorities. We offer suggested rationales for them, and will delve more into the theories of change by program approach in the 1999 site visits. Three differences were seen in the spring 1998 priorities:

- Home-based programs emphasized the combination of parent-child relationships and child development outcomes to a greater degree than did center-based and mixed-approach programs. Perhaps because home-based programs have often been seen as focusing on parental self-sufficiency, Early Head Start home-based programs may have been making special efforts to emphasize child development outcomes and the parent-child relationships outcomes that lead to them.

- Center-based programs emphasized family development and staff development outcomes to a greater degree than did programs following the other approaches. While most services were child-oriented, center-based programs may have felt a special need to keep the family as well as the child in the forefront. In addition, staff development may have received special attention in these programs since staff in center-based programs were being paid the least and received the fewest benefits (see Chapter III), and keeping these staff engaged and committed is critical for success in all other areas.

- Mixed-approach programs were most likely to give high priority to community development outcomes. Many of these programs were working with community partners to provide child care for Early Head Start children; thus, they may have placed a greater emphasis on targeting outcomes related to improving the quality of community services, especially child care.

As in all other aspects of programs' early theories of change, the final round of site visits in 1999 will update and expand on the information presented here.

4. The Perspective of Programs' Success Stories

As useful as the theory-of-change process is for understanding programs' expected outcomes, efforts to dissect staff thinking run the risk of decontextualizing the important work that programs do. When asked to talk about individual families and children, program staff quickly described a complex array of circumstances, needs, services, and outcomes. The directors' success stories help to illustrate both the specific outcomes they value and the complex ways in which multiple program expectations interact. Table II.12 summarizes success stories from three programs. Although each

TABLE II.12

ILLUSTRATIVE PROGRAM SUCCESS STORIES

The "Baylors"

When 10-month-old "Pamela" first entered her center-based Early Head Start program, she was identified as "failure to thrive," and weighed just 10 pounds. With a large head, tiny body, and translucent skin, she showed little affect, meekly whimpered, and had virtually no language development. She could barely sit up, had no balance, and expressed little interest in exploring her new environment. The community child care center from which she came had allowed her to spend most of the day lying in her crib. Fortunately, Pamela's mother was determined to make this placement work, and provided hope to the teachers who had little experience with a child showing such profound needs. As the teachers gained Pamela's trust, she gradually began to explore her world, discovering she could sit without support, then "scoot" toward desired objects, and thus maneuver around her classroom. All center staff carefully observed her progress and celebrated Pamela's response to the programs' naturally inclusive environment. Seven months after entering the program, Pamela had become the center's official greeter, welcoming visitors with her effervescent smile and sparkling eyes. She was fitted for a hearing aide and was beginning to verbalize. Meanwhile, her advocate-mother began exploring a career in human services, possibly with a focus on services for children with disabilities.

The "Jacksons"

"Tina Jackson" was living in an abusive relationship with the father of her two young children when she enrolled in the local Early Head Start home-based program 18 months ago. Herself a victim of abuse and neglect as a child, Tina had difficulties meeting the developmental needs of two young children, one with serious asthma. Through the Early Head Start intervention, Tina was able to obtain her GED, leave the violent relationship with the father, obtain a driver's license, and begin to purchase the car that would allow her greater independence and ability to meet the medical, educational, and social needs of her children. She enrolled in computer classes at the local community college and became a member of the Head Start Policy Council. The most important changes noted by program staff was in the quality of Tina's relationship with her children, the increased time she spent with them, and her greater attention to their physical, cognitive, and emotional growth and development.

The "Smiths"

"Alicia Smith," the 16-year-old mother of a developmentally delayed 1-year-old, "Adam," had been physically abused by the baby's father. Alicia was exhausted, nonresponsive, uninterested in her appearance, and--critically--oblivious of her baby, who was developmentally delayed, irritable, and cried excessively. Her mixed-approach Early Head Start program began weekly home visits by the family educator, who tutored her, modeled good hygiene practices, and provided needed transportation to the center, where Adam was assigned a primary caregiver who provided individualized parent-child activities. The program called upon a number of collaborating agencies (including mental health, family preservation, and vocational rehabilitation) to provide coordinated services. The program's parent educator began meeting with the father, who started participating in the fathers' program.

Within a year, Alicia became more responsive to Adam's physical needs and verbal interactions. At the same time, Adam became better able to communicate his needs for bodily care, food, and other things. His language, self-help, and gross motor development improved noticeably, and he now actively explores his environment and initiates contact with familiar adults. Alicia communicates more freely with program staff, takes greater interest in her appearance, and has expressed interest in receiving support services. The father has returned to live with the mother and child and has begun actively seeking employment while continuing to work cooperatively with an intensive home services therapist.

story is unique, and it is difficult to select three that represent the full diversity of programs' identified successes, clear themes emerge. Regardless of program philosophy, theory of change, or stated intention, low-income families with infants face many obstacles. As these stories illustrate, programs have no choice but to address families' problems with health, employment, housing, transportation, and abusive relationships. It is easy to read these programs' success stories as success in moving young mothers toward self-sufficiency. However, it is also clear from these experiences that programs' broad concerns for the whole family and the mothers' self-sufficiency exist because of an underlying desire to change the context in which the infant lives and develops. Furthermore, regardless of program approach, we see program efforts to enhance the parent-child relationship for the ultimate purpose of improving the child's developmental chances.

5. Implications

As we noted at the beginning of our discussion of theories of change, by understanding programs' intended outcomes and their strategies for achieving them, program evaluators can vastly improve their opportunities to understand the outcomes they measure. In this discussion, we have focused on the programs' intended outcomes; the rest of this report describes the diverse strategies that programs implemented for achieving many of these outcomes. A full discussion of the detailed linkages between specific program services and intended outcomes will require further input from program staff and their local research partners.

III. PROGRAM ACTIVITIES AND SERVICES

The Early Head Start program guidelines and the revised Head Start Program Performance Standards provide the framework for Early Head Start services. They specify the parameters for high-quality child and family development services, direct program managers to work with staff to enhance their skills and promote their professional development, and encourage programs to collaborate with other community agencies. They also require that programs do community needs assessments and develop implementation plans, including plans for continuous program improvement activities. Within this framework, Early Head Start programs are allowed flexibility to design services to meet the specific needs of families in their communities.

In fall 1997, the Early Head Start research programs were taking diverse approaches to serving children and families. Some provided child and family development services primarily in regular, frequent home visits. Others offered center-based child development services and provided family development services in less-frequent meetings with parents, either at the center or in families' homes. Still others mixed these approaches, providing services to some families in centers and to others in home visits. The programs took a variety of approaches to ensuring that children received high-quality child care, from providing care directly to making referrals to local child care resource and referral agencies to establishing collaborative agreements with child care providers and giving them training and technical assistance. The programs also involved parents in group activities, such as monthly parent meetings and intensive play groups with children.

The research programs vary in the emphases they place on particular goals and outcomes. They vary also in the ways they have implemented particular services for children and families. The purpose of this chapter is to describe these activities and services. The third volume of this report will analyze the degree of program implementation in the key program areas and overall. The following sections describe various approaches and services as the research programs carried them out at the time of the site visits in fall 1997. These include recruitment and enrollment strategies; child and family development services; characteristics, training, supervision, support, and well-being of staff members; community partnerships; and management of operations.

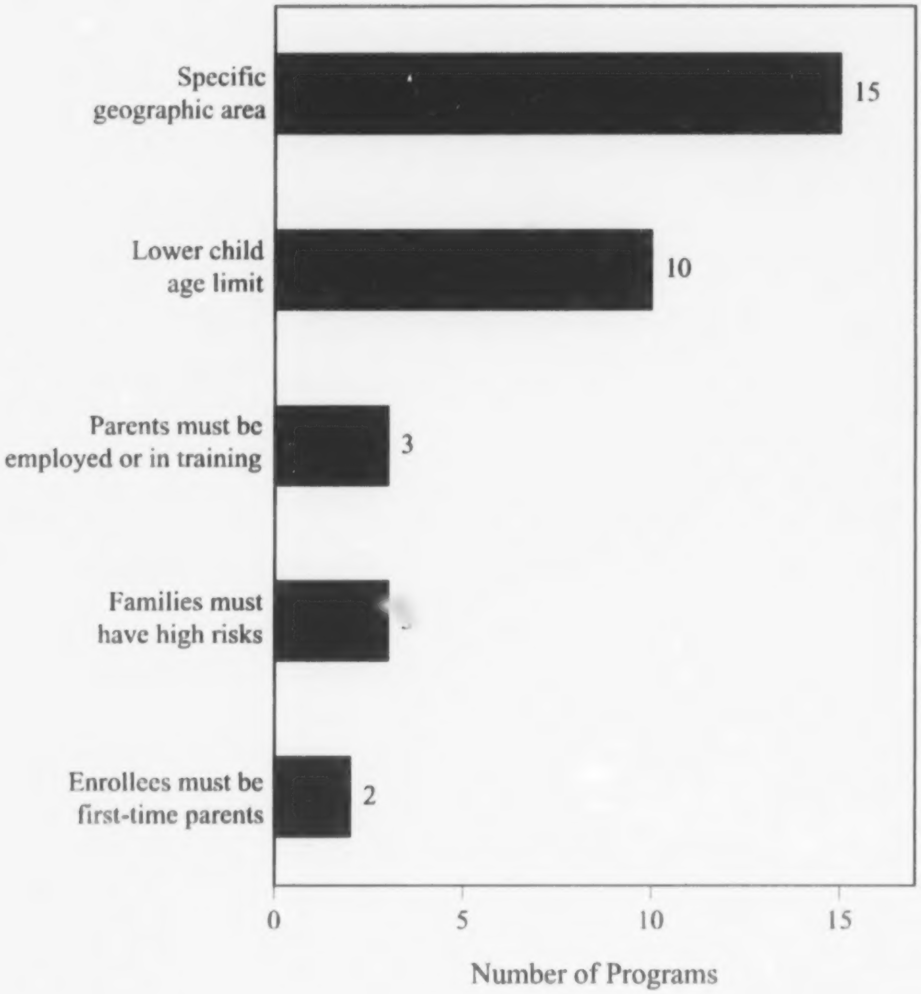
A. RECRUITMENT AND ENROLLMENT

The Early Head Start guidelines specify that programs may enroll "pregnant women and families with children under age 3 who meet income criteria specified in the Head Start regulations." However, the guidelines also note that Congress encouraged programs to identify participants while pregnant or while their children are infants (U.S. Department of Health and Human Services 1995). According to the criteria specified in the Head Start Act, children are eligible if their families' incomes are below the poverty line, or if their families would be eligible for public assistance if they could not find child care to enable them to work. The Head Start regulations require that at least 90 percent of families must have incomes below the poverty level, and at least 10 percent of children must have disabilities (U.S. Department of Health and Human Services 1996).

Individual programs can impose additional eligibility criteria. For example, most of the research programs specifically limited eligibility to families living in certain geographic areas (Figure III.1). In addition, because the EHS research included only families whose children are under age 1 (or unborn), many of the research programs imposed this age requirement on all families. To facilitate the local research, a few limited age eligibility even further or selected different age criteria. Several research programs required that parents be working, in training, or attending school when they apply. Two programs limited eligibility to first-time parents, although, to increase the pace of enrollment, one of them expanded eligibility midway through the first year to include mothers of two children

FIGURE III.1

ADDITIONAL ELIGIBILITY CRITERIA
ADOPTED BY EARLY HEAD START RESEARCH PROGRAMS



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

if one is an infant. Three programs limited eligibility to particularly high-risk families. One of them served only families with two or more issues identified in a psychosocial assessment. The other limited eligibility to intrastate migrants. In a third, eligibility at one site was limited to homeless, substance-abusing parents.

Most programs adopted multiple strategies for recruiting families. Nearly all programs sought referrals from other service providers in the community, and most distributed flyers or hung posters to advertise their services. Another common strategy was to go door to door to identify potentially eligible families and tell them about the program. Many of the programs also reached out to families at neighborhood events or at other community agencies, such as WIC offices. Several programs advertised program services in public service radio, television, or newspaper announcements.

Most of the research programs had funds to serve 75 families at one time. One program was smaller (45 families), while six were larger (100 to 140 families). The Head Start Bureau required that programs reach full enrollment within one year of receiving funding. Thus, the research programs in the first wave of funded programs were expected to be fully enrolled by October 1996. However, many research programs did not meet the deadline, primarily because of the research eligibility criteria and the need to recruit two families for every program vacancy.[1]

The dynamic nature of families' lives and participation in program services led enrollment to fluctuate over time in some programs. Programs usually try for some time to persuade families who stop participating in program activities to return. Eventually, however, they remove unresponsive families from the rolls and offer services to new families. While staff members are trying to re-engage families who have stopped participating, the families remain on the rolls and are counted as being in the program. Some of the programs reported that they had lost some families by the time of the 1997 site visits. At least four programs reported that more than 20 families dropped out after enrolling, usually for the following reasons: (1) families did not want to participate at the expected levels or wanted services different than those offered by the program, (2) families moved out of the area, (3) contact with families lapsed when there was staff turnover, and (4) other commitments or family stresses interfered with families' ability to participate. At the time of the site visits, six programs were not fully enrolled, and two additional programs reported that they were not actively serving all enrolled families.

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[1] Enrollment into the research sample continued from June 1996 through September 1998. Eligibility for the research was limited to families with children under age 1 who were born within a 37-month period (June 1995 through July 1998).

B. CHILD DEVELOPMENT SERVICES

Early Head Start is a program designed to help children develop fully by providing "individualized support that honors the unique characteristics and pace of their physical, social, emotional, cognitive, and language development" (U.S. Department of Health and Human Services 1995). Head Start regulations require that programs supply services to promote child health, to foster positive relationships between the child and parents and other significant caregivers, to provide opportunities for children's active engagement in appropriately stimulating environments, and to enhance parents' knowledge of child development. However, programs have flexibility to design and implement services that will best meet the specific needs of their clients.

1. Center-Based Child Development Services

One of the approaches that Early Head Start programs may take to deliver child development services is center-based child care, which may be particularly appropriate when the target population served by Early Head Start includes many low-income working families. Nine of the research programs (the four center-based and five mixed-approach programs) provided child development services to some or all families in Early Head Start child care centers in fall 1997. In most of the centers, child care was available full-time for families who needed it. One program, however, offered only part-time care (in two 2.75-hour sessions each day). All the centers were open during standard working hours, but not on evenings or weekends, when some working families needed child care.

In most centers, staff members reported that infants and toddlers were cared for in small groups of eight or fewer.[2,3] For infants alone, the reported maximum group sizes ranged from 4 to 10, with six programs having groups of eight or fewer. Reported maximum group sizes for toddlers ranged from 6 to 14, with five programs having groups of 8 or fewer. Center-based and mixed-approach programs reported similar maximum group sizes in their centers.

Staff in all programs reported relatively small maximum child-staff ratios. The maximum ratio for infants was 3 to 1 in four programs and 3 or 4 to 1 in the remaining five (Figure III.2). The maximum ratios reported for toddlers were slightly higher. In seven programs, the maximum ratio for toddlers was 3 or 4 to 1. In one program, the maximum ratio was smaller (2.7 to 1), and in one program it was larger (5 to 1). As with group sizes, center-based and mixed-approach programs reported similar maximum ratios in their centers.

In most of the centers, children were assigned to a primary caregiver. However, two programs took a team approach to caring for children and did not assign children to primary caregivers.

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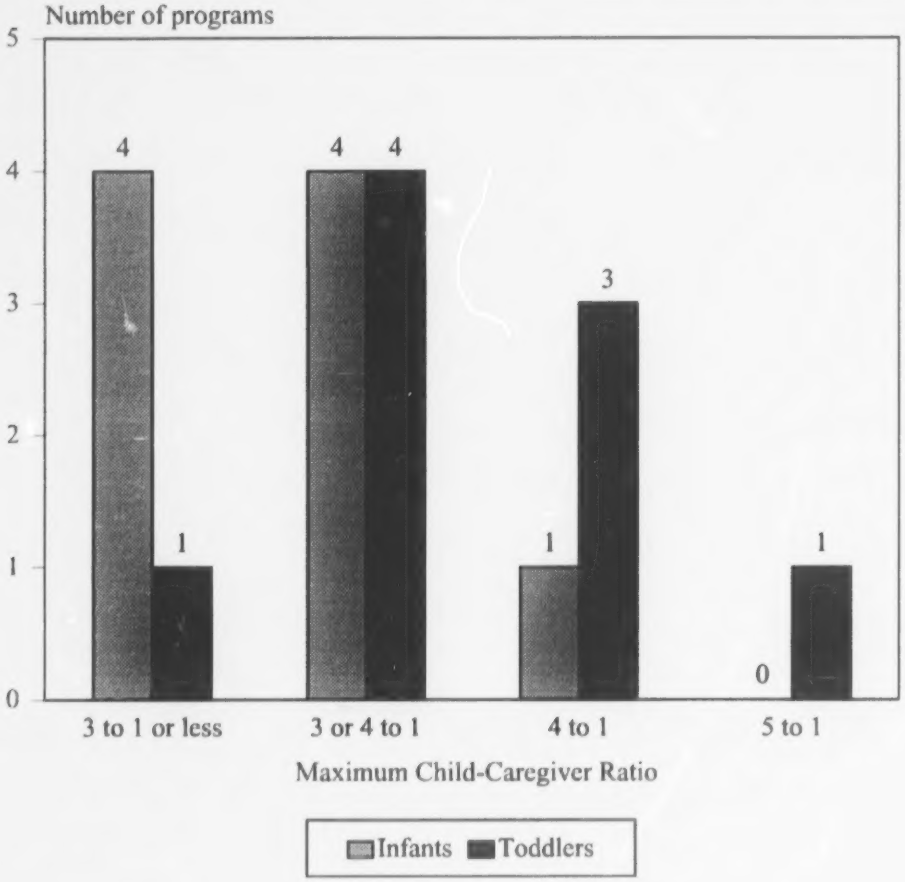
[2] Group sizes and child-caregiver ratios are also being observed in connection with child care data being collected for the national evaluation of Early Head Start, and future reports will discuss the observed group sizes and ratios in the Early Head Start centers.

[3] The revised Head Start Program Standards, which did not take effect until shortly after the site visits, set the maximum group size for infants and toddlers at eight children and the maximum child-staff ratio at 4 to 1. Programs were monitored shortly after the new standards took effect in January 1998, and the Head Start Bureau expected some changes to occur after the monitoring visits.

FIGURE III.2

MAXIMUM CHILD-CAREGIVER RATIOS IN CENTERS
(AS REPORTED BY STAFF)



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

Center staff members drew on a variety of materials to plan activities with children and, in most programs, relied on multiple resources. Two programs used the High/Scope curriculum/approach. Three programs drew on WestEd's *Program for Infant/Toddler Caregivers* materials, and four drew on the *Creative Curriculum for Infants and Toddlers*. Other materials mentioned include *Partners in Parenting Education, Resources for Infant Educators, Hawaii Early Learning Profile, Partners in Learning, Games to Play with Babies, Games to Play with Toddlers, Playtime Learning Games for Young Children, Talking to Your Baby, Learning Activities for Infants, Ones and Twos*, the *Anti-Bias Curriculum*, and Montessori.

Center staff members in most of the programs either had a Child Development Associate (CDA) credential (or its equivalent or a higher degree) or were working toward a CDA.[4] In one program, center managers were comparing the CDA requirements with the extensive Montessori training provided for center caregivers and were planning to request that Montessori be accepted as equivalent.

2. Home-Based Child Development Services

Another approach that Early Head Start programs may take to providing child development services is to visit homes to conduct activities and support parents. Home-based services recognize the importance of parents in fostering child development and support them in fostering the growth and development of their children. Thirteen of the research programs provided child development services to some or all families through the home-based option.

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[4] The Child Development Associate (CDA) National Credentialing Program, administered by the Council for Early Childhood Professional Recognition, is a training effort to improve the quality of child care. Individuals apply for a CDA credential by providing documentation of training and experience in the early childhood care profession to the council for assessment according to national standards.

Most of the 13 programs offering home-based services planned the required weekly home visits to families that received child development services primarily in such visits (Figure III.3).[5] Three programs planned less-frequent visits (two or three visits per month). In one home-based program, the planned frequency of home visits was biweekly if the child was in developmentally appropriate child care in the community or weekly if the child was not.

The actual intensity of home visiting that staff members reported was usually less than planned.[6] Most of the programs reported that, on average, they were able to visit families two or three times per month, and one program was able to visit families an average of only once a month (Figure III.3). The program that planned biweekly home visits reported that home visitors were able to make them. Among the 10 programs that planned weekly visits with some or all families, 3 reported that they were able to make them.

Staff members reported that conflicts with school or work, illnesses, and difficult family circumstances often prevented families from keeping appointments for home visits. Families receiving welfare cash assistance faced work requirements and time limits on receipt. Because they were giving priority to meeting these requirements and finding jobs, these families often did not have time for weekly home visits. Many families lived in difficult circumstances, and some program staff members reported that they were just not able to comply with a schedule of weekly home visits plus other program activities. Scheduling difficulties, illnesses, and bad weather also interfered with completing some home visits.

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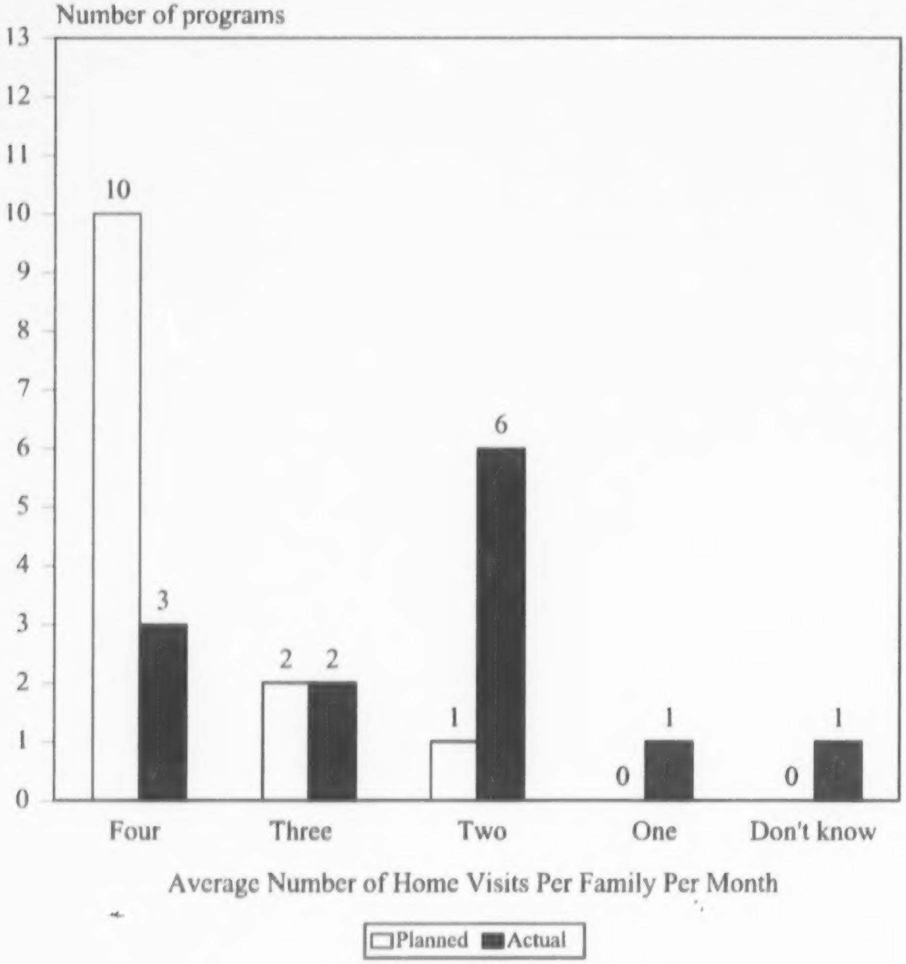
[5] Home-based programs are expected to offer one home visit per week (48 to 52 visits per year). Programs may offer home-based services less frequently if they are provided in combination with center-based services.

[6] Programs are completing forms to document completed home visits, and in the future it will be possible to document the actual frequency of home visits more precisely.

FIGURE III.3

PLANNED AND ACTUAL FREQUENCY OF HOME VISITS IN EARLY HEAD START RESEARCH PROGRAMS TAKING A HOME-BASED OR MIXED APPROACH, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

NOTE: Four programs reported completing the planned number of visits per family, on average (three that planned weekly visits and one that planned biweekly visits).

Caseload sizes of home visitors varied, in part depending on the number of visits the program planned to complete each month. Home visitors in about half the home-based and mixed-approach programs had caseloads of 10 or 12 families (Figure III.4). Home visitors in three programs had slightly higher caseloads (13 to 15 families), and home visitors in three others had even higher caseloads (20 to 25 families). Two of these were mixed-approach programs, and the caseloads of some home visitors contained some families who were receiving child development services in other ways and received only monthly home visits. Caseload sizes of home visitors did not differ systematically between home-based and mixed-approach programs.

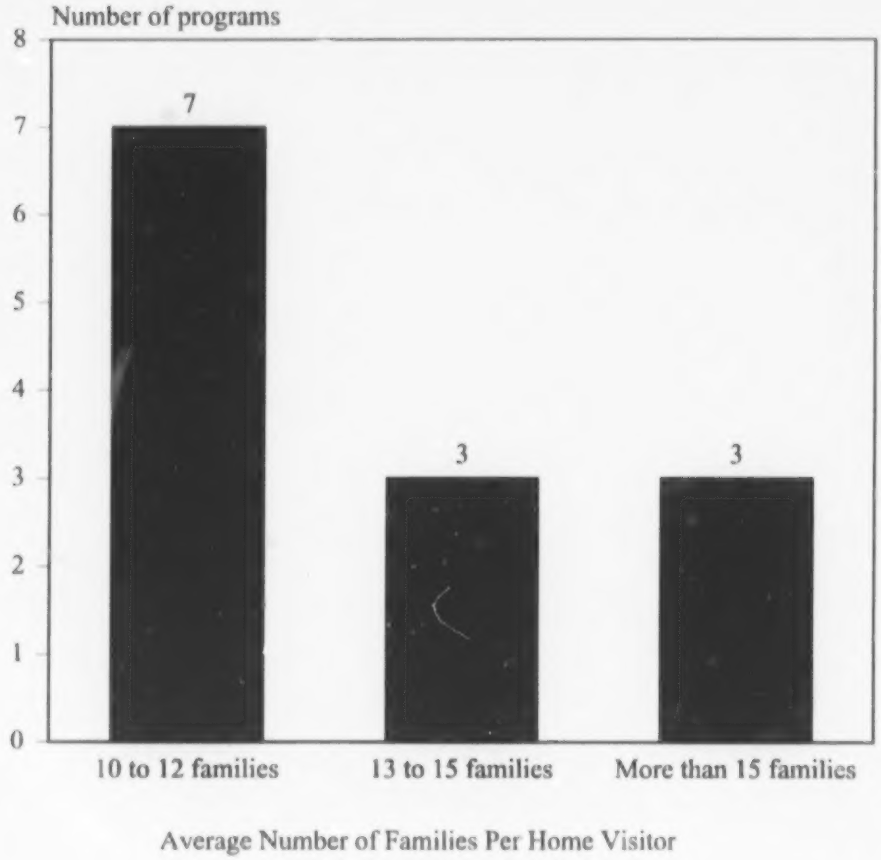
Some of the programs offering home-based services hired professional home visitors, while others hired paraprofessionals. Most required that home visitors have a postsecondary educational credential or be working toward one. Five programs and one site of a sixth required home visitors to have at least a bachelor's degree. Six programs required home visitors to have a CDA, a college degree, or an associate's degree. One program offering both home-based and center-based options and three out of four centers in another home-based program required home visitors to have a high school diploma.

Home visitors in all the programs offering home-based services drew on existing materials to plan home visits. The most commonly used were the *Parents as Teachers* curriculum (five programs) and WestEd's *Program for Infant/Toddler Caregivers* (five programs). Home visitors in several programs drew on the *Partners in Parenting Education* curriculum, *Early Learning Accomplishment Profile* materials, or *Hawaii Early Learning Profile* materials.

According to staff members' reports, the percentage of time home visitors spent on child development during a typical home visit (a typical child development home visit, if the program

FIGURE III.4

HOME VISITOR CASELOADS, FALL 1997



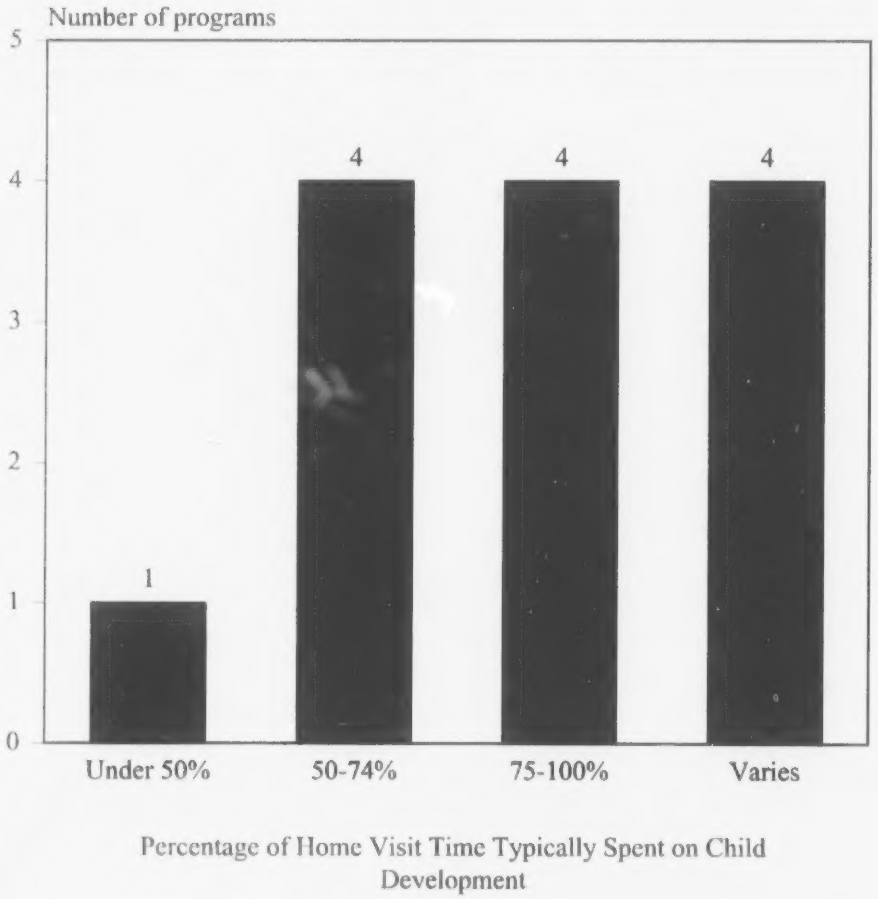
SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

conducted more than one type of visit) varied widely across programs, and in some cases, within programs. In estimating the proportion of time spent on child development, staff members included any activities that they considered applicable. In four programs, staff members indicated that the amount of time spent on child development activities varied based on family needs, and they could not give an estimate (Figure III.5). Four programs reported that home visitors typically spent between three-quarters and all of the time on child development activities (in two of these programs, families also received home visits from other staff members to address family development issues). Four programs reported that home visitors usually spent between half and three-quarters of the home visit time on child development activities. In one program the amount of time typically spent on child development was estimated to be 20 percent. The amount of time typically spent on child development did not vary systematically between home-based and mixed-approach programs.

Staff members' reports indicated that children's involvement in the typical home visit ranged from the entire visit to very little of it. Children's involvement tended to be highest in programs that provided family development services in separate home visits (so child development home visitors did not have to address family development issues) and in programs that planned activities using the *Parents as Teachers* curriculum (which facilitates direct involvement with the child). Among the nine programs that estimated how much home visit time was typically devoted to child development activities, six estimated that at least half the visit was spent with the child (either alone or together with the parent). In the remaining three programs, staff members gave an estimate of one-third or less.

FIGURE III.5

TYPICAL TIME SPENT ON CHILD DEVELOPMENT IN HOME VISITS, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

3. Child Care Arrangements

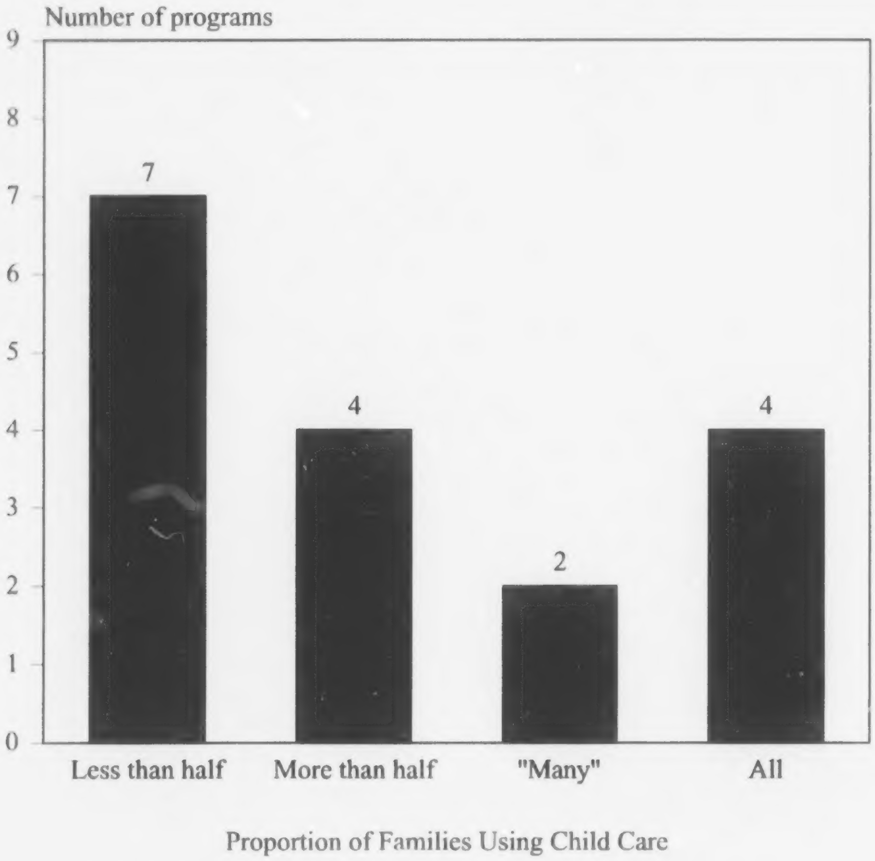
In fall 1997, the need for child care by low-income parents of infants and toddlers was increasing as families began responding to the new work requirements imposed by the 1996 welfare reform legislation. The Early Head Start program guidelines require that programs provide part- and full-day child care services as needed by children and families. They may provide these services directly or by helping families obtain appropriate child care. When programs are brokering child care services in the community, they are responsible for ensuring that the child care settings meet standards for high-quality, developmentally appropriate care (U.S. Department of Health and Human Services 1995), in compliance with the revised Head Start Program Performance standards.

In all the programs, a significant proportion of families were using child care, either the Early Head Start center or another child care provider in the community. In the four center-based programs, virtually all children were receiving Early Head Start child care (Figure III.6). In two of these programs, an estimated one-fifth to one-third of the children were also in other child care arrangements (in one program, many children were in wraparound care provided by the agency; in the other program, some families were receiving care in other arrangements temporarily until one of the program's centers opened). In four additional programs (three of them mixed-approach), more than half of enrolled children were in some kind of child care arrangement (most often Early Head Start child care), and in two programs, directors reported that "many" children were in child care. In seven programs, fewer than half of enrolled children were in child care. In most of these programs, the figure was about one-third.

At the time of the site visits, six of the research programs were taking some or all of the required steps to ensure that children for whom they were not directly providing child care received high-quality child care in a community setting, beyond teaching parents what to look for in selecting a

FIGURE III.6

ESTIMATED PROPORTION OF FAMILIES USING CHILD CARE, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

child care arrangement. In the initial stages of program implementation, the requirement to oversee the quality of care received by Early Head Start children in community child care settings was not clear to all programs, and seven research programs were not taking steps to ensure high-quality child care.

Of the 13 home-based and mixed-approach programs, 2 were trying to assess, monitor, and promote the quality of the community settings in which Early Head Start children were receiving care. One of these referred families only to providers that it had determined provided developmentally appropriate child care. Program coordinators spent time in the centers and in family child care homes, provided feedback and technical assistance, and planned training to address issues they identified. The program provided monthly training sessions for child care providers. Another program identified high-quality centers and family child care homes that had openings, then accompanied parents on visits to the providers and helped the parents make an informed choice. A program coordinator made both announced and unannounced visits to the providers who cared for Early Head Start children and communicated with them frequently by telephone. The coordinator also provided training and technical assistance to the providers.

Two other programs either assessed the quality of child care arrangements before placing children or helped parents do so. They did not, however, monitor the quality of the arrangements once placements were made, nor did they supply ongoing training to providers. One program helped families assess the quality of child care arrangements using the *Infant-Toddler Environment Rating Scale* (ITERS). Another used National Association for the Education of Young Children accreditation criteria and the revised Head Start Program Performance Standards to assess the quality of child care centers and licensed family child care homes to which it referred families.

Two other programs that did not assess or monitor the quality of child care arrangements for particular families tried to improve the quality of child care in their communities by offering CDA training to community providers. One mixed-approach program invited other community providers to CDA training it conducted for its center staff and family child care providers. Another program worked with a resource and referral agency to provide mentoring assistance to providers who were setting up family child care homes and becoming licensed. It also offered CDA training to anyone interested in providing family child care.

4. Other Child Development Services

Early Head Start programs also are required to conduct developmental, sensory, and behavioral assessments; to provide child health services, including helping families identify and obtain the services of a consistent health care professional who can provide ongoing care for their children; and to offer group socialization activities.

Developmental Assessments. All the research programs regularly and frequently assessed the developmental progress of enrolled children. These assessments helped to identify children with potential disabilities and served as the basis for child development activities with children and parents. For example, many programs used the assessments for planning activities with children in the centers or during home visits, and several programs used them to help parents develop goals for their children and to plan specific parent-child activities. In some cases, parents actively participated in conducting the assessments. The most commonly used tools were:

- *Denver Developmental Screening Test II* (six programs)
- *Ages and Stages Questionnaires* (six programs)
- *Early Learning Accomplishment Profile* (four programs)

•• *Hawaii Early Learning Profile* (four programs)

Child Health Services. All the research programs checked on children's immunization status and receipt of health care, followed up with parents when necessary, and made referrals to health care providers. Many programs also provided additional health care and/or health education services, either directly or through collaboration with community agencies (Figure III.7). Six programs conducted on-site health screenings or provided on-site care, either by medical staff they employed or through collaboration with health care providers. Seven programs reported that they provided health education in home visits and/or parent meetings. Ten programs conducted health screenings and/or provided health care during home visits (most often through nurses who were either employed by the program or provided by another agency). Two programs reported that staff members accompanied parents on health care visits.

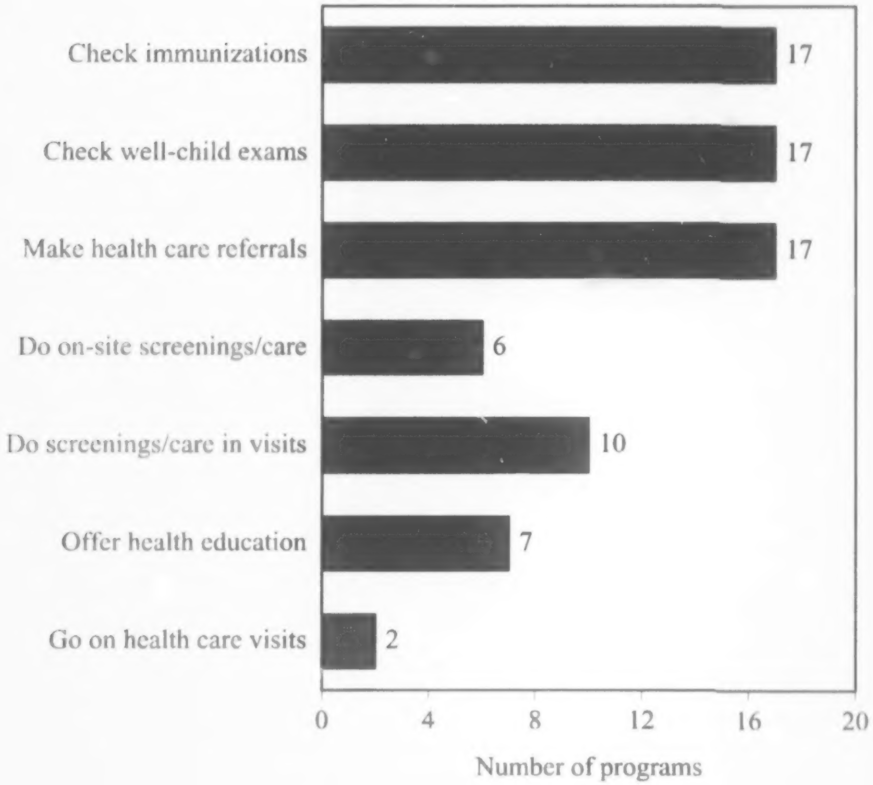
At the time of the site visits, some programs were still trying to arrange medical homes for some enrolled children. Nine programs reported that at least 90 percent of enrolled children had a medical home, an additional five gave a figure of between 80 and 89 percent, and three programs did not know the percentage.

The proportion of children reported to have up-to-date immunizations varied widely among the research programs. Not all programs could report precise percentages, but among those that could, the figures ranged from under 70 percent to 100 percent. Similarly, in many programs at the time of the site visits, some children had not had a well-child examination. While six programs reported that all children had had them, four programs reported a figure of under 80 percent.

All the programs had enrolled some children with suspected or diagnosed disabilities by the time of the site visits. Most programs reported a figure of at least 10 percent, which the revised Head Start Program Performance Standards require. Of these, six programs reported a figure of at least

FIGURE III.7

CHILD HEALTH SERVICES, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

15 percent. Six programs reported that fewer than 10 percent of enrolled children had disabilities. Many programs were still in the process of assessing children with suspected disabilities to determine if they qualified for special services.

Group Socialization Activities. The Early Head Start program guidelines specified that programs must provide parent education, including parent-child activities. Most of the programs offering home-based services to some or all families invited families to regular group activities at least once a month (although the revised Head Start Program Performance Standards recommend two group socializations per month across all Head Start and Early Head Start programs offering home-based services). The frequency of these activities for parents and children varied from monthly in some programs to biweekly or weekly in others. In some programs, the frequency of group socialization activities varied across program sites or at different times of year. Group activities included classes, play groups, picnics, family outings, and special events on particular themes. At the time of the site visits, many of the programs reported that attendance at group activities was fairly low (typically 10 to 30 families per session or event). Because of poor attendance, one program had discontinued group socializations and was redesigning them, and another program was considering offering them on weekends.

5. Extent of Participation in Child Development Services

If child development services are to be effective, they must be regular. During the month before the site visits, most enrolled children participated in the program and received some services. Staff in eight programs, including all four center-based programs, reported that all enrolled children had received child development services during the previous month. Staff of five additional programs cited a figure of at least 85 percent, and staff in two gave a figure of less than 85 percent. In one of these programs, new staff members were re-establishing contact with some families who had not been actively participating, and in the other, home visitors had difficulty completing visits with some families.

C. FAMILY DEVELOPMENT SERVICES

The Early Head Start program guidelines and revised Head Start Program Performance Standards recognize that "healthy child development depends on the ability of parents and families to support and nurture children while meeting other critical social and economic needs" (U.S. Department of Health and Human Services 1995). Therefore, they require that programs (1) help parents set goals and incorporate them into individual family development plans, and (2) provide a range of services to help parents achieve those goals. The following sections describe how programs conducted needs assessments and service planning and provided family development services, parent involvement opportunities (including special efforts to involve fathers), and family health services in fall 1997.

1. Needs Assessment and Service Planning

The revised Head Start Program Performance Standards require that Early Head Start programs form partnerships with parents as soon as possible after enrollment and offer them the opportunity to develop and implement Individualized Family Partnership Agreements (IFPAs), though the exact nature of the process and of the forms to be used is not prescribed. In any case, all the research programs had a process in place and forms to use for assessing family needs and developing IFPAs. In one program, the process was informal and families were not required to enter into an IFPA, but at the time of the site visit, the program was planning to formalize the process.

At the time of the site visits, the families were in various stages of completing IFPAs, in part depending on how long they had been enrolled. Nine programs reported that they had established

IFPAs with all enrolled families, and three reported that they had done so with at least 80 percent. Some families who had not established IFPAs had enrolled recently and had not yet completed the process. In five programs, staff reported a figure of less than 80 percent. In these programs, staff had not succeeded in completing the assessment and service planning process with some families, some families became inactive before completing an IFPA, some families resisted setting formal goals and instead had informal agreements, and families in some programs were not required to enter into an IFPA. The frequency with which families' IFPAs were updated varied considerably across programs, ranging from "continual" to monthly to annually. Some programs updated IFPAs during regular, formal meetings; other programs updated them more informally as needed.

Most research programs engaged in joint needs assessment and service planning with local Part C programs.[7] Five programs did not develop such joint plans, but in most cases, they tried to follow the Part C Individual Family Service Plan or tried to coordinate services.

None of the research programs was engaging in joint service planning with the welfare agency at the time of the site visits. Three programs reported that they worked closely with the welfare agency in other ways (two incorporated welfare self-sufficiency contracts into their work with families, and one worked closely with the welfare agency when families were having problems and faced sanctions). Two additional programs reported that they were planning to or wanted to engage in joint service planning with the welfare agency.

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[7] Part C (formerly Part H) of the Individuals with Disabilities Education Act provides federal funds to assist states in planning and implementing a system of coordinated, comprehensive, multidisciplinary, interagency programs to provide appropriate early intervention services to all infants and toddlers with disabilities and their families. All states serve infants and toddlers with diagnosed developmental delays or diagnosed conditions that have a high probability of resulting in developmental delay, and they have the discretion to serve infants and toddlers and their families who are at risk of having substantial developmental delays if early intervention services are not provided.

2. Family Development Services

The revised Head Start Program Performance Standards require that programs work with parents to identify and obtain, either directly or through referral, needed services and useful resources, including assistance with emergencies, education, counseling, and employment. All the programs provided case management to link families with needed services in the community. The extent to which families had met with their case manager (a home visitor or other staff member who worked with them on family development) in the month prior to the site visit varied across programs. In most programs, however, staff members reported that 80 percent or more of enrolled families had met with their case manager in the previous month.[8]

At the time of the fall 1997 site visits, most of the programs were serving some families receiving TANF cash assistance who were or would soon be facing work requirements. In addition to providing referrals to employment-related services, nine programs offered various types of education and employment services to families (Figure III.8). Four conducted skill assessments, and four offered job search and/or job placement services. Three programs offered workshops on employment topics, and two offered on-site GED courses. Other education and employment services offered by at least one of the programs included tutoring for parents who were students, a monthly employment support group, and special efforts to support parents' interactions with employers.

Many families in the Early Head Start research programs reported having transportation needs when they enrolled, and most of the programs helped with transportation. Nine programs used vans or buses to transport families to services and appointments. Two provided families with bus passes or taxi vouchers, and six programs reported that staff members provided transportation as often as possible to families who needed it.

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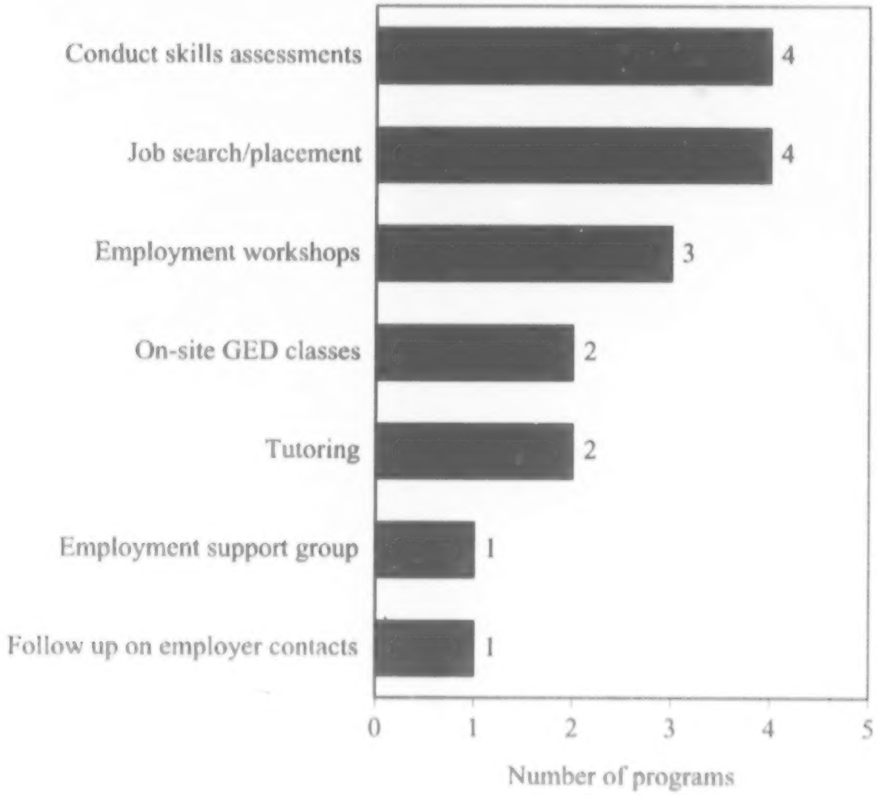
[8] Two programs could not provide a precise estimate of the percentage of families who had met with their case manager.

FIGURE III.8

EDUCATION AND EMPLOYMENT-RELATED SERVICES, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

All the research programs provided referrals for emergency assistance, and a few provided emergency food or money directly. Several programs kept funds they could draw on in emergencies; one required families who received assistance to work with staff members to create a budget. One program had made arrangements with a local bank to make loans to families with emergency needs.

3. Parent Involvement Opportunities

The Advisory Committee on Services for Families with Infants and Toddlers recommended that the new Early Head Start programs create and maintain an environment that supports the highest level of partnership with both mothers and fathers. The committee advised programs to support parents as primary caregivers of their children, to offer each parent the opportunity for experiences that support his or her goals, and to provide a policy- and decision-making role for parents (U.S. Department of Health and Human Services 1994b). The revised Head Start Program Performance Standards emphasize the importance of involving parents in program governance and activities and of using them as employees and volunteers.

The research programs encouraged parents to become involved, both by participating in program governance and social activities, and by volunteering. All the research programs either had or were forming policy councils at the time of the site visits (Figure III.9).[9] Seven of the eight programs operated by Head Start grantees had or were forming a joint Head Start-Early Head Start policy council. Ten programs had or were forming independent Early Head Start policy councils. Ten programs had also formed parent committees, usually center committees and finance committees, to involve more parents.

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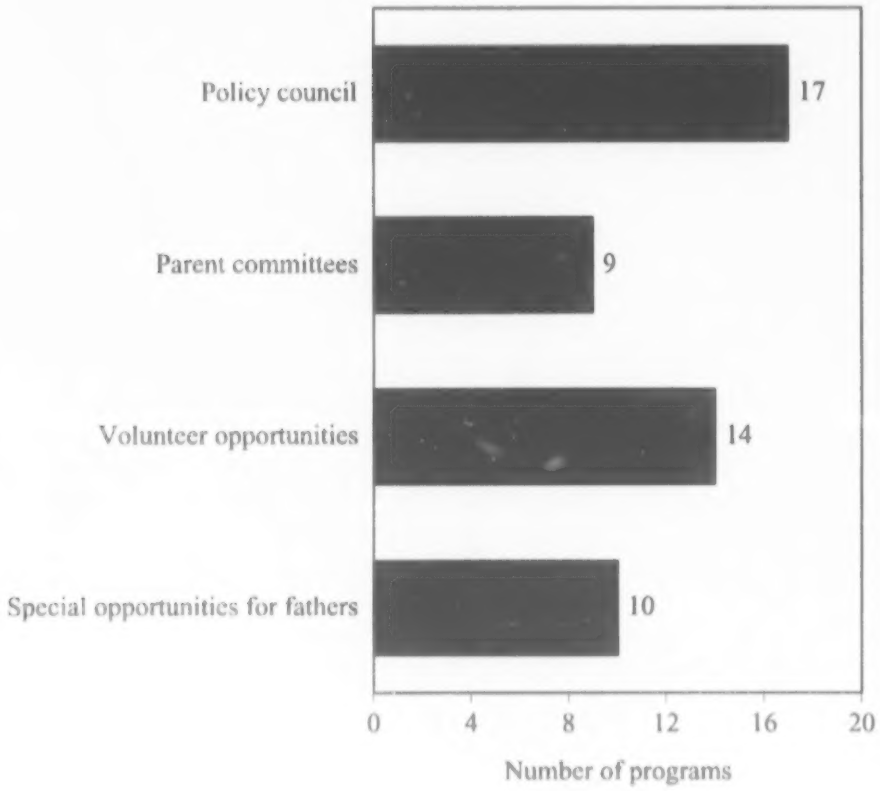
[9] The revised Head Start Program Performance Standards require programs to form a policy council, which is the formal group of parents and community representatives that assists in planning and operating the program.

FIGURE III.9

PARENT INVOLVEMENT OPPORTUNITIES, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

Most of the research programs provided opportunities for parents to volunteer. Ten programs involved parents in planning, organizing, and conducting program activities, including parent meetings and social events. Six involved parent volunteers in center operations, such as staffing a toy-lending library or a clothing or food bank, doing repairs, or helping in the kitchen. Four programs with center-based child development services involved parents as volunteers in the classrooms. Three programs used parent volunteers to assist with filing or other office work, three involved parents in outreach or recruiting activities, and two had parents provide transportation or serve as bus monitors. Programs also used parents as translators, involved them in peer support, and sought their contributions to program newsletters. Three programs--all home-based--did not involve parents as volunteers at the time of the site visits.

The degree to which Early Head Start parents were involved in volunteer activities varied dramatically across programs. Eight programs reported that at least half of enrolled parents were involved in volunteer activities. Six reported that some, but fewer than half, volunteered. Center-based and mixed-approach programs tended to offer more opportunities for parent involvement, in part because they could have parents help in their classrooms.

4. Special Efforts to Involve Fathers

In recommending that parental involvement be key to the conceptual design of the Early Head Start program, the Advisory Committee on Services for Families with Infants and Toddlers urged that special efforts be made to welcome and support fathers as parenting partners (Department of Health and Human Services 1994b). Accordingly, all the programs invited and encouraged fathers to participate in regular program activities and become involved as parents. One program strongly encouraged the father to be present during the enrollment process, so that staff members could explain his roles and participation in the program and include him in the family's IFPA. Several programs had made special efforts to make the program environment more male-friendly--for example, by hanging posters of fathers and children, making the center decor more gender-neutral, or holding special "meet and greet our men" events.

Ten of the research programs offered special services for fathers and father figures. An additional program collaborated with a community agency to offer special services. Many of these programs (seven) employed staff members (usually men) who were responsible for working with and involving fathers and provided support to other staff members working with fathers. Seven programs convened a monthly fathers' support group, either as part of Early Head Start or in collaboration with a community agency. Six programs organized recreational activities for men only, and three used special curricula or modules for fathers in their work with families.

5. Family Health Services

All the research programs helped families apply for Medicaid and made referrals to health care providers. If families were not eligible for Medicaid, the programs helped them apply for other health insurance available to low-income families, referred them to providers who would care for low-income families, or, as a last resort, paid for needed health care.

All the Early Head Start research programs provided prenatal education and care either directly or through referrals. Twelve programs provided it during home visits, and two additional programs provided prenatal classes. The rest of the programs collaborated with or made referrals to other agencies for prenatal education. For prenatal care, most of the programs referred pregnant women to health care providers, while two employed nurses or health specialists to visit pregnant women at home.

In addition to making referrals for mental health care needs, many of the research programs offered services, either directly or through collaboration with other agencies. Ten provided counseling or therapy to families, two convened parent support groups or organized parent meetings, and two assessed children's and families' needs and made referrals to community providers. Eleven mentioned supplying special staff training on mental health issues and/or employing a specialist to consult with staff about them.

All the programs referred families to the Special Supplemental Feeding Program for Women Infants, and Children (WIC), food pantries, and other agencies, but many also provided other nutrition services. Five programs employed or had access to a nutritionist to train and consult with staff or work with families, and five provided nutrition education in home visits or parent meetings. Four (two center-based and two mixed-approach) participated in the Child and Adult Care Food Program, and four programs conducted nutritional assessments with families. Other nutrition services mentioned during the site visits include weekly cooking classes, emergency food boxes, requiring parents to bring nutritious food to the center for their children, and quarterly food festivals.

D. STAFF DEVELOPMENT[10]

The Advisory Committee on Services for Families with Infants and Toddlers recognized that "programs are only as good as the individuals who staff them." Thus, the Early Head Start program goals include ensuring the provision of high quality, responsive services through the development of highly trained, caring, and adequately compensated program staff members (U.S. Department of Health and Human Services 1995). As a result, staff development is a strong focus of the 17 Early Head Start research programs.

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[10] The information in this section is based primarily on data from questionnaires completed by program staff members during the fall 1997 site visits. Overall, 356 staff members in the 17 research programs (93 percent) completed questionnaires.

In fall 1997, the programs employed between 8 and 38 mostly permanent, full-time staff members. The different staff sizes reflect the variations in program sizes and approaches, as well as differences in the levels of staff support provided through other programs the grantee operated (for example, the extent to which Head Start coordinators also provided support to Early Head Start staff). The programs with the smallest staff sizes tended to be home-based programs operated by agencies that were also Head Start grantees, while programs with the largest staff sizes tended to be those serving families in center-based programs. The programs that served larger numbers of families also tended to employ more staff members.

1. Staff Demographics

The vast majority of staff members in the Early Head Start research programs in fall 1997 were female. The staff of five programs was entirely female, and in eight programs, more than 90 percent of staff members were female.

In most programs, a substantial proportion of staff members were married, which suggests that they probably had both personal and financial support outside the program. Three-fourths of staff members had children of their own and thus could draw on their own parenting experiences in developing relationships with the families.

To a large extent, the racial/ethnic composition of staff members in the programs reflected that of the families the programs served and differed substantially in only three programs. Five programs served some African American families but did not employ any African American staff members (except for one program, all these programs served only a small proportion of African American families). Six programs served a small number of Hispanic families but did not employ any Hispanic staff members.

For the most part, the percentage of staff hired by the research programs who spoke Spanish was similar to or greater than the percentage of enrolled families who were Hispanic. In three programs, the proportion of staff members who spoke Spanish was considerably less than the proportion of enrolled families who were Hispanic; however, the proportion of staff members who spoke Spanish was comparable to the proportion of enrolled families who did not speak English well.

Many staff members reported that they had lived in a neighborhood served by the Early Head Start program. In 10 of the research programs, the majority of staff members had lived in program neighborhoods at some time, and in most of the remaining programs, a significant proportion had done so. Many of the staff members who had ever lived in a program neighborhood were living there in fall 1997.

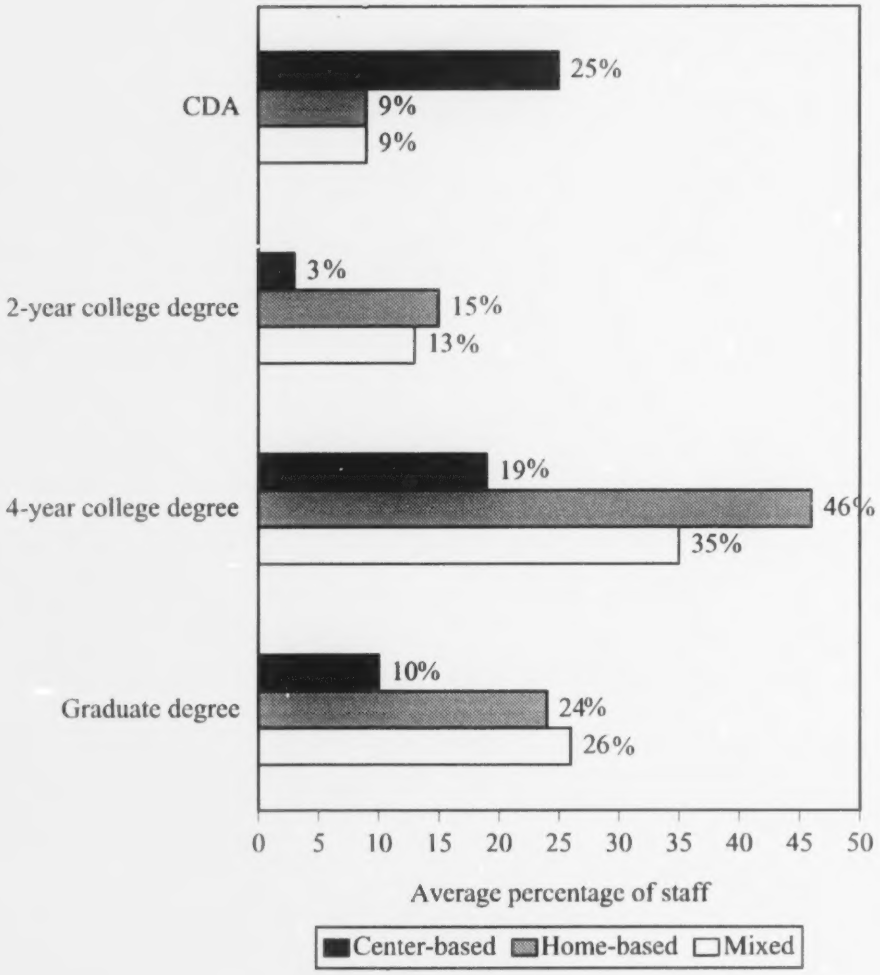
Nearly one-fifth of staff members were or had previously been Early Head Start or Head Start parents. The extent to which staff members were or had been Early Head Start or Head Start parents varied widely, however, from 0 to 38 percent.

2. Needs Assessment and Staff Training

The nature and extent of training needed by Early Head Start staff members depends in part on their education and experience. The 17 Early Head Start research programs employed highly educated staff members: 20 percent had a graduate degree, 14 percent had taken some graduate courses, and 24 percent had a four-year degree. In addition, 12 percent had earned a two-year degree. Staff members in center-based programs were more likely than staff members in other types of programs to have a CDA credential (Figure III.10). Staff members in home-based and mixed-approach programs were much more likely than those in center-based programs to have a 4-year college degree or a graduate degree (70 and 61 percent versus 29 percent).

FIGURE III.10

HIGHEST EDUCATIONAL ATTAINMENT OF ALL STAFF BY PROGRAM APPROACH, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

Overall, 14 percent of staff members had a CDA credential, and an additional 14 percent were participating in CDA programs at the time of the site visits. In a few programs, 40 percent or more of staff members had a CDA, while in five programs, no staff members had one (but they did have other relevant qualifications). Staff members in center-based programs were more likely to report having a CDA than a college degree.

Most programs reported conducting assessments of staff training needs, either formally through staff surveys or less formally through discussions with and observations of staff. Program directors and coordinators used these assessments to develop staff training plans. Nine programs reported that they work with staff members to develop individual plans in addition to these overall, programwide plans.

Most of the programs reported that staff members received preservice orientation and training, and in some programs, the preservice training was extensive. For example, one program provided three months of such training to home visitors on infant-toddler development, family development, health and wellness, community collaboration, and Head Start policies. In several programs, the preservice training was designed to lead to certification in the use of a particular curriculum (such as *Parents as Teachers*) or approach (such as Montessori).

All programs provided regular staff in-service training, either in group sessions or through individual observation and feedback. In some programs, time was set aside each week or each month for training sessions, while in other programs, training was integrated into regular staff meetings. Some programs encouraged staff members to attend additional training through other community organizations or at national conferences.

Staff members' assessments of the usefulness of the training they had received in the 12 months prior to the site visits varied substantially. Overall, about three-fourths of staff members reported that it was very beneficial, but only 41 percent indicated that the training would be very likely to change how they do their work. Across the 17 Early Head Start research programs, however, the percentage of staff members who reported the training to be very beneficial ranged from 36 to 100 percent. The percentage who reported that the training was very likely to change how they do their work ranged widely, from 11 to 100 percent.

The vast majority of staff members reported that they planned to attend more training in the future, 91 percent because they wanted to learn more, and nearly half because it was required for their job. Between one-fifth and one-fourth of staff members also cited the need for credits and the enjoyment of the social aspects of training.

In addition to their extensive training opportunities, most of the research programs encouraged staff members to participate in other development activities, including classes, certification programs, workshops, and professional meetings. Many of the programs encouraged staff members to attend conferences, workshops, and classes and provided leave time and funds so they could do so. Several programs set aside a fixed dollar amount for each staff member to use as he or she chose for professional development activities.

3. Staff Supervision and Support

The Advisory Committee on Services for Families with Infants and Toddlers recommended that ongoing staff training, supervision, and mentoring be integrated into staff development (U.S. Department of Health and Human Services 1994b). Through strong supervision, both in groups and with individual staff members, program managers can support frontline staff and help them meet the challenges and manage the stress of their responsibilities.

All the research programs reported convening regular staff meetings so that program managers could supervise and support frontline staff members (the home visitors and center caregivers). These meetings also gave staff members opportunities to provide and receive peer support. Most programs held meetings weekly, while two programs held them biweekly and one program held them monthly. In mixed-approach programs, separate meetings were often held with center teachers and home visitors.

Informal mentoring of new or junior staff by senior staff often occurs naturally without any action by program managers, but not all staff members may receive such mentoring. Several of the research programs assigned mentors to new staff members to ensure that they all received special support and guidance from someone with experience.

Most programs conducted regular performance reviews with staff members. Twelve programs conducted them annually, three programs did so more frequently, and one did so less frequently. One program did not conduct regular staff performance reviews, but managers observed staff members regularly, assessed their performance, and provided feedback and training to address any issues identified.

Program managers also provided individual support and supervision to frontline staff. In most programs, directors and coordinators provided individual supervision informally, as needed. A few programs scheduled regular opportunities for individual supervision. In many of the home-based programs, coordinators periodically accompanied home visitors on visits and provided individual feedback.

4. Wages and Benefits

The Advisory Committee on Services to Families with Infants and Toddlers noted that high-quality staff performance and development are linked to rewards such as salary, compensation, and career advancement (U.S. Department of Health and Human Services 1994b). The wages of frontline staff members (home visitors and center teachers) in the research programs were relatively low: on average, $9.77 per hour at the time of the site visits. The average hourly wages in the programs ranged from $6.37 in a mixed-approach program to $14.18 in a program employing master's-level home visitors.

Most staff members in the research programs reported receiving key fringe benefits. Approximately 86 percent reported receiving paid health insurance for themselves, and 58 percent reported receiving it for family members (Figure III.11). Three-quarters of staff members reported receiving dental insurance, and three-quarters also reported receiving pension or retirement benefits. Most reported receiving paid vacation time (88 percent) and paid sick leave (93 percent). About one-third of staff members reported receiving compensation for overtime work.

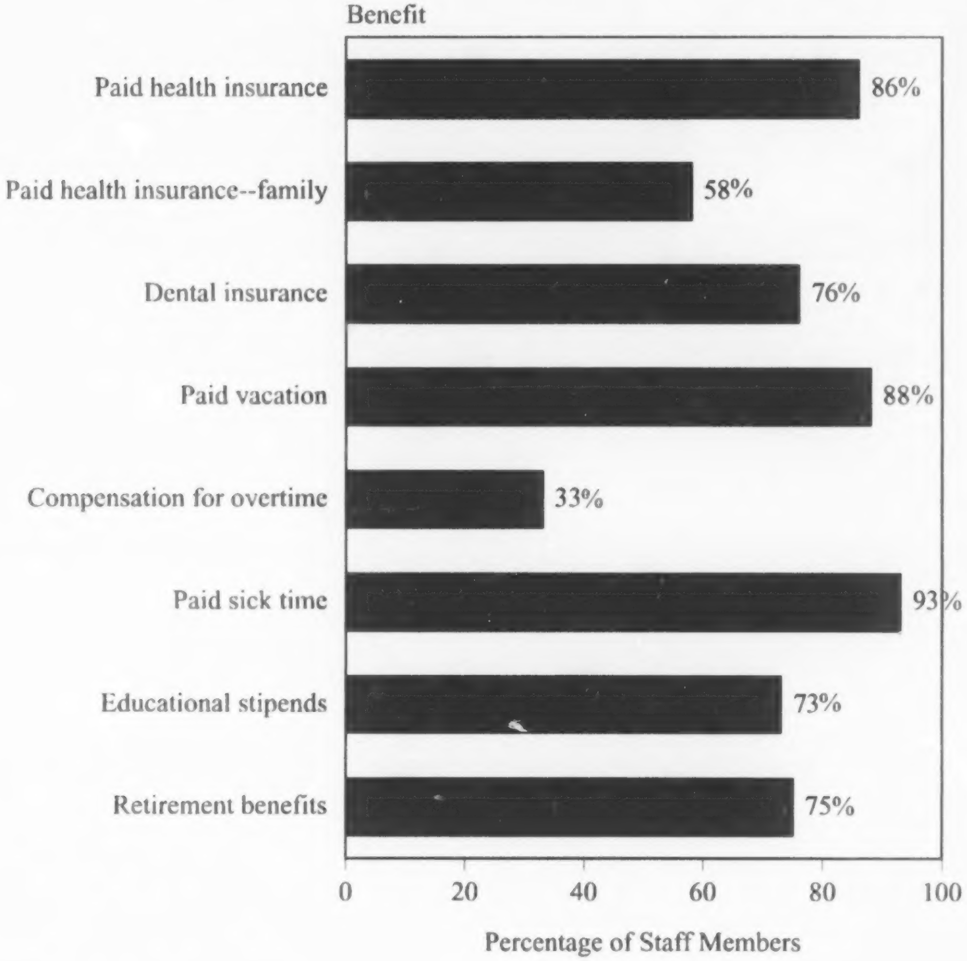
Staff members in home-based and mixed-approach programs were more likely than those in center-based programs to report receiving most key benefits (pension, paid vacation, and paid health insurance) (Figure III.12). Staff members in home-based and mixed-approach programs were also more likely to receive educational stipends.

Consistent with the low wages and benefits of child care center staff nationally, staff members of the center-based Early Head Start programs reported the lowest average hourly wages and were least likely to report receiving significant fringe benefits. The 4 center-based programs ranked last among the 17 research programs, in terms of average hourly wages of frontline staff members ($8.41) and the percentage who reported receiving pension benefits, life insurance, and paid health insurance for themselves and their dependents.

The Early Head Start research programs that paid the highest average hourly wages to frontline staff and provided benefits to higher percentages of staff members were home-based programs that did not operate child development centers. These programs tended to hire home visitors with college or graduate degrees, or they operated in areas where the cost of living was high. The average hourly wage of frontline staff in the home-based programs was $12.00.

FIGURE III.11

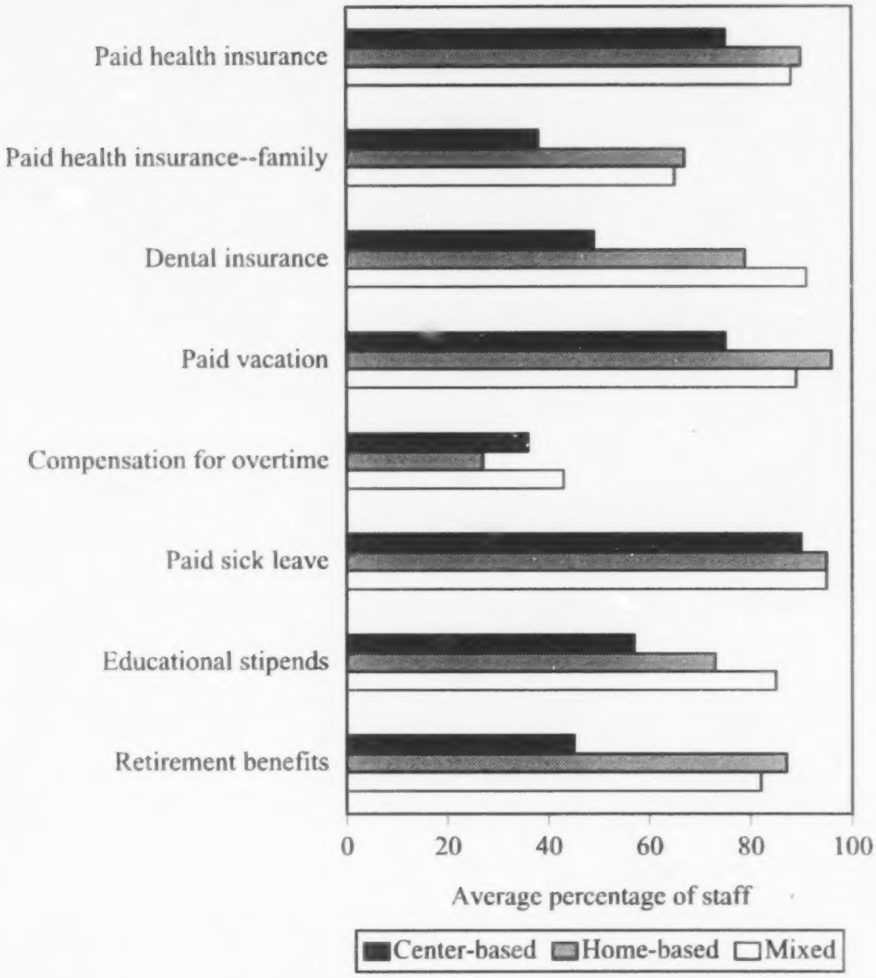
FRINGE BENEFITS RECEIVED BY STAFF
IN EARLY HEAD START RESEARCH PROGRAMS, FALL 1997



SOURCE: Self-administered surveys of staff completed during visits to the Early Head Start research programs in fall 1997.

FIGURE III.12

FRINGE BENEFITS RECEIVED BY STAFF, BY PROGRAM APPROACH, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

Although the wages the programs paid were low, they were consistent with those of center teachers and home visitors generally. All program directors reported that staff salary and benefit levels were at or above those of other similar positions in their areas. In most programs, staff members expressed dissatisfaction during the site visits with what they perceived as low salary levels. Only 38 percent of staff members who completed the staff survey agreed that their salary was satisfactory. One program reported having trouble filling open positions at the salaries offered.

5. Staff Retention

The emphasis on strong, caring, continuous relationships in the principles set forth by the Advisory Committee for the Early Head Start program highlights the importance of maintaining a stable program staff. On average, program directors in the research programs reported that 20 percent of permanent staff members had left and been replaced. Staff turnover rates ranged from 0 to 50 percent. Four programs experienced high levels of staff turnover (one-third of their staff or more). In most cases, staff members left voluntarily, but two programs had asked at least one staff member to leave.

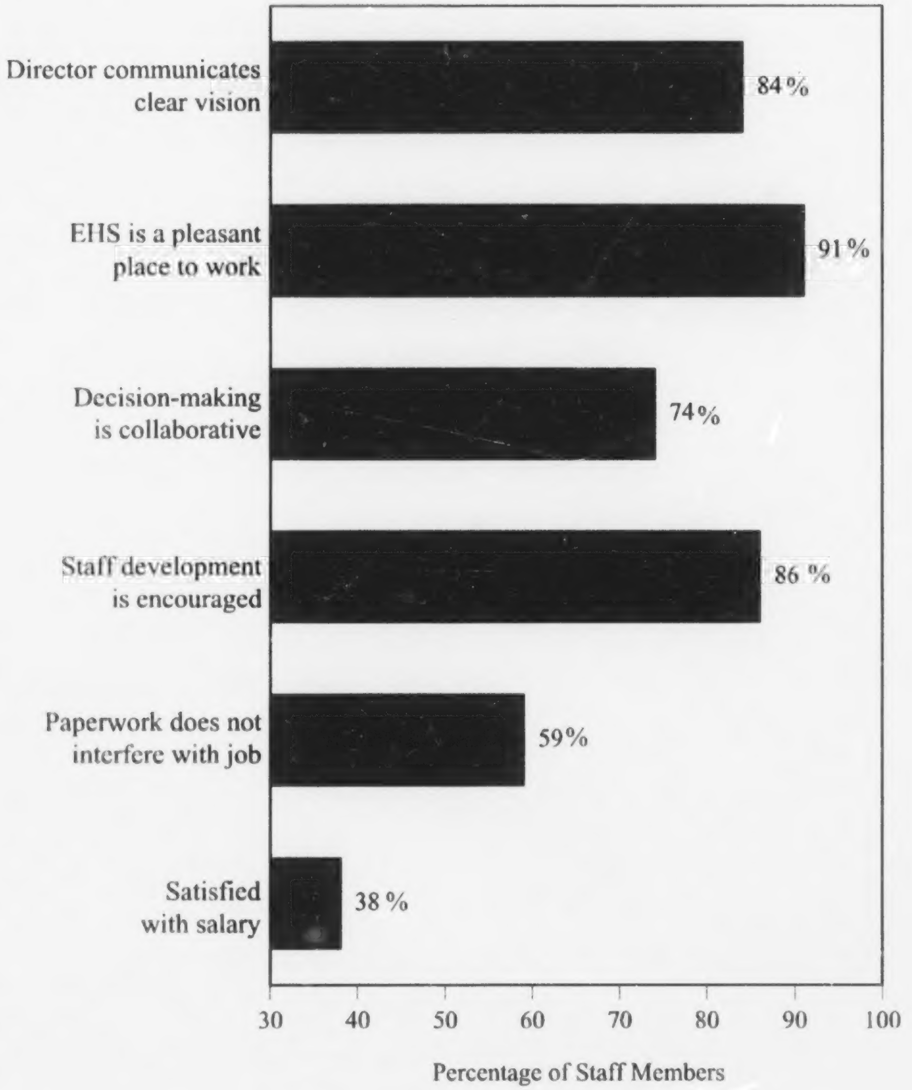
Three programs, all with relatively high rates of staff turnover, underwent changes in leadership by the time of the site visits (at the end of two years of funding and one year of serving families). These changes were accompanied by low staff morale and, in some cases, turnover in other staff positions that led to disruptions in services to some families.

6. Workplace Climate

The workplace climate in the research programs at the time of the site visits was very positive, and staff members rated their Early Head Start programs very highly (Figure III.13). More than 90 percent reported that their Early Head Start program was a pleasant place to work and said that staff

FIGURE III.13

WORKPLACE CLIMATE, FALL 1997



SOURCE: Self-administered surveys of staff completed during visits to the Early Head Start research programs in fall 1997.

members shared ideas. Ninety-three percent described their relationships with other staff members as cooperative or very cooperative, and about three-fourths reported that decision-making was collaborative and that they were included. Eighty-six percent felt that the program encouraged staff development, and 85 percent agreed that materials they needed were available. Only a small proportion of staff members reported that they sometimes had to follow rules that conflicted with their judgment.

Staff members also rated their program directors highly. Eighty-four percent indicated that their director communicated a clear vision for the program. Approximately three-fourths agreed that their director recognized a good job, kept them informed, and had realistic expectations.

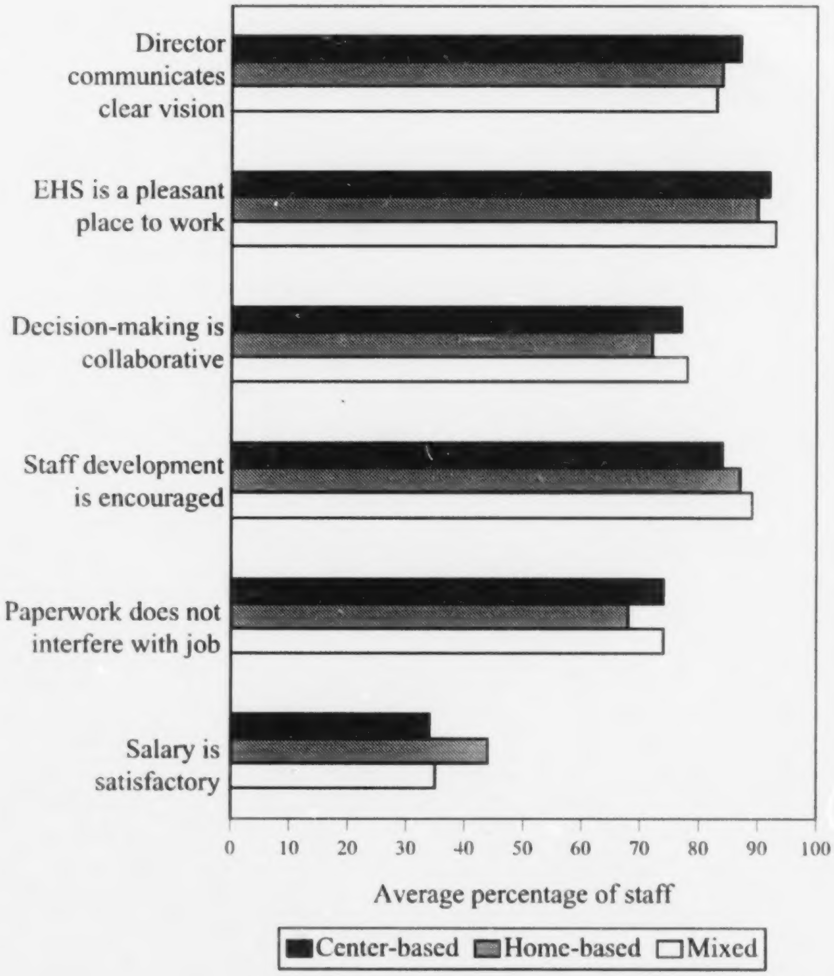
Many staff members had concerns in two areas--salaries and paperwork. Nearly two-thirds of staff members indicated that they were not satisfied with their salaries, and only about 60 percent of staff members reported that paperwork did not interfere with their job.

Staff members in center-based, home-based, and mixed-approach programs held similar opinions about their workplace (Figure III.14). Staff members of center-based programs were slightly more likely than those in other types of programs to report that their director communicated a clear vision for the program. They were also slightly less likely to report that program administrators encourage staff development. Staff members in home-based programs were slightly less likely than those in other types of programs to report that paperwork does not interfere with their job. They were also somewhat more likely to be satisfied with their salary.

Although staff members at the research programs were generally positive in their assessments of their work environment, at some programs they expressed varying degrees of dissatisfaction. In two programs, staff members were less likely to agree with various positive statements about their workplace environment and about their program director. Both of these were home-based programs

FIGURE III.14

WORKPLACE CLIMATE,
BY PROGRAM APPROACH, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

in which low staff morale was reportedly an issue. In five programs, staff members were more likely to agree with various positive statements about their workplace environment. Three of these programs were home-based programs, and two were mixed-approach programs.

7. Job and Career Satisfaction

Virtually all staff members in the Early Head Start research programs felt their work to be worthwhile and enjoyed it. All of them reported that they put in a lot of effort. Most staff members also felt that their work uses their skills.

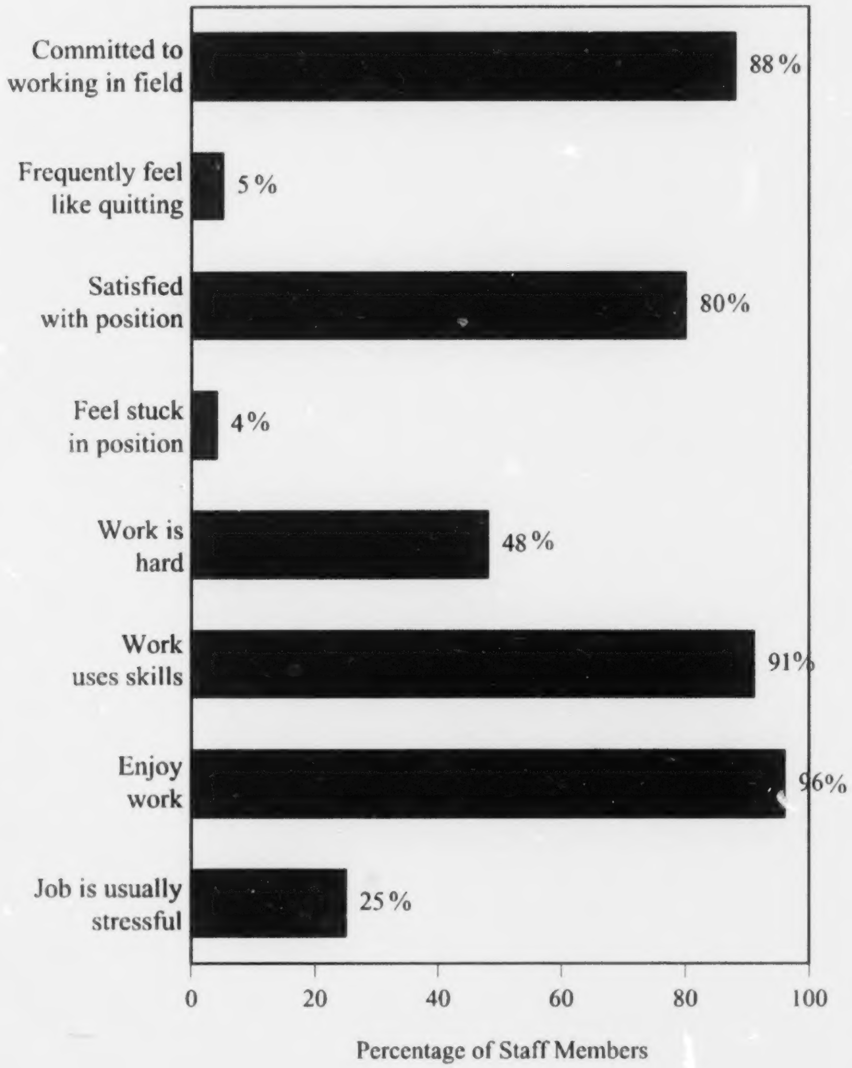
About half the staff members indicated that their work is difficult (Figure III.15). The proportion agreeing that their work is hard ranged from 11 percent in one home-based program to 78 percent in a mixed-approach program. Although not all staff members thought their work was hard, only five percent thought it was boring.

Even if they were less satisfied with their work environments, most staff members in the Early Head Start research programs were satisfied with their jobs and very committed to working in the early childhood field. Overall, 80 percent of staff members reported that they were satisfied with their position in the Early Head Start program. Very few staff members--about five percent overall--reported that they frequently felt like quitting their jobs or felt stuck in their current position. Half of them reported that they saw their current position as their chosen occupation, and an additional 28 percent saw it as the first step in their field.

Levels of job satisfaction were quite similar among staff of center-based, home-based, and mixed-approach programs (Figure III.16). Although the differences are small, staff members in center-based programs were slightly less likely than those in other types of programs to report that they were committed to working in the field and they were slightly more likely to report that they frequently felt like quitting.

FIGURE III.15

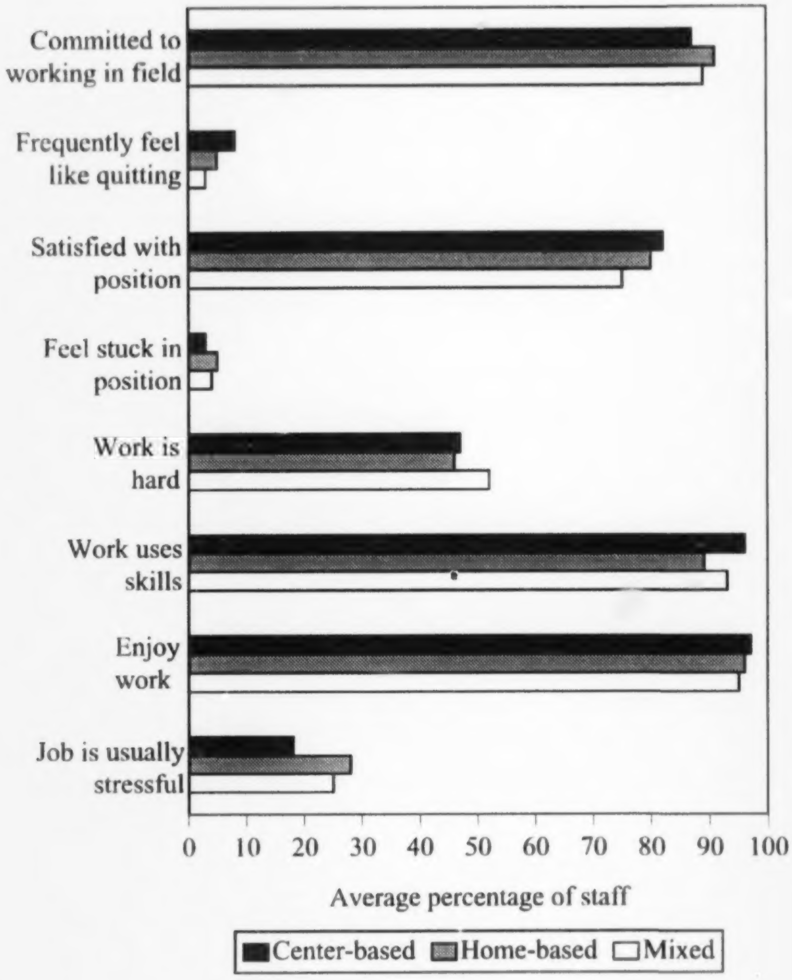
JOB SATISFACTION, FALL 1997



SOURCE: Self-administered surveys of staff completed during visits to the Early Head Start research programs in fall 1997.

FIGURE III.16

JOB SATISFACTION, BY PROGRAM APPROACH, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

All or nearly all of the staff members in several programs were satisfied with their position, and many saw their current position as their chosen occupation. Job satisfaction at some research programs was lower, however. In one home-based program, only 62 percent of staff members were satisfied with their position, 27 percent felt stuck in their current position, and 18 percent said that they frequently felt like quitting. In another home-based program, only 68 percent of staff members were satisfied with their position in the program, the same proportion felt that their work was hard, and 9 percent reported that they frequently felt like quitting. In two other programs in which fewer than 70 percent of staff members were satisfied with their position, many staff members saw their current position as a first step in the field, and no staff members reported feeling that they were stuck in their current position.

8. Health Status and Job Stress

Most staff members (86 percent) reported being in excellent health, only 3 percent described it as fair or poor, and only 7 percent reported that it was worse than it had been a year ago. Approximately 10 percent of staff members reported that they had cut down the time they spent on work or other activities because of physical or mental health problems during the month prior to the site visits, but only 3 percent said that a physical or mental health problem limited their social activities a great deal in that time.

Although their health was good, some staff members reported experiencing stress at work. Overall, one-fourth of staff members in the Early Head Start research programs reported that their job was always or usually stressful. However, the extent to which they felt this way varied substantially across the 17 programs from 0 percent in a center-based program to 63 percent in a home-based program. In general, staff members in center-based programs were less likely than staff

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members in home-based and mixed-approach programs to report that their job was always or usually stressful.

E. COMMUNITY PARTNERSHIPS

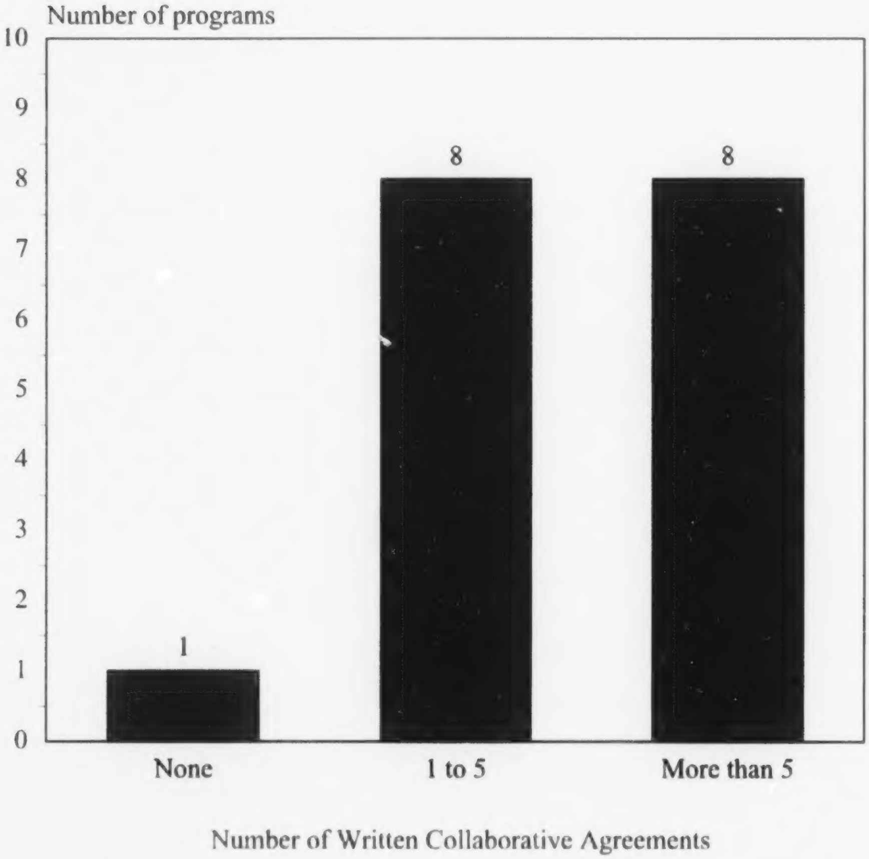
In setting forth the goals of Early Head Start, ACYF recognized that children develop within the context of the family, and that families develop within the context of the community. Thus, community-building is an explicit goal of Early Head Start, and the revised Head Start Program Performance Standards require Early Head Start programs "[to] take an active role in community planning to encourage strong communication [and] cooperation and the sharing of information among agencies and their community partners, and to improve the delivery of services to children and families." Programs are also required to establish and maintain a Health Services Advisory Committee, as well as other service advisory committees as appropriate to address program service issues (U.S. Department of Health and Human Services 1996).

The research programs had formed numerous partnerships with community agencies, and almost all of them participated in interagency coordination groups in their communities. Nearly all the programs had a formal written agreement to collaborate with at least one community agency, and half had such agreements with more than five community agencies (Figure III.17). In addition, nearly all programs reported having informal agreements with at least one community agency. One program reported having no such formal agreements, but it did have informal ones with a large number of agencies. The collaborative agreements ranged from general agreements to support each other to agreements to exchange referrals or to provide services.

Many of the Early Head Start research programs had "major" partners--that is, they were collaborating with one or several other community agencies to provide important services to Early Head Start families. Programs were most likely to forge close working relationships with the local

FIGURE III.17

FORMAL COMMUNITY PARTNERSHIPS, FALL 1997



SOURCE: Information gathered during visits to the Early Head Start research programs in fall 1997.

Part C program. At the time of the site visits, 11 of the 17 research programs were collaborating with the local Part C agency to develop joint IFSPs and to coordinate services for families with children with disabilities. The remaining programs reported that they followed the Part C IFSPs for families with children with disabilities, and in some cases, they also participated on the Part C Local Interagency Coordinating Council.

The Early Head Start research programs were also likely to develop working partnerships with health care providers. Ten programs had done so, six to provide mental health services to families, and six to provide physical health services.

Working partnerships with other types of community agencies were less common. Seven programs were working with child care providers or local child care resource and referral agencies. Through these partnerships, the programs conducted staff cross-training and/or arranged for developmentally appropriate child care for Early Head Start children who needed care, training to become a family child care provider for Early Head Start parents, drop-in care for Early Head Start families, or space for an Early Head Start center.

Seven of the research programs were collaborating with education or job training providers in their communities to provide special services to Early Head Start families. Through these partnerships, programs provided GED classes to Early Head Start parents, arranged for in-house skills testing to be accepted by local job training providers, arranged support for families trying to obtain education or employment, and/or facilitated access for Early Head Start parents to ESL, child development, or job training classes.

Four programs were collaborating with the local welfare agency. Through these partnerships, programs were coordinating services for families facing sanctions, cross-training staff, arranging for welfare agency staff members to be located at the Early Head Start center, and/or serving as welfare-to-work training sites.

All the programs reported participating in interagency coordination groups in their community. In many cases, Early Head Start staff members were leaders of the interagency groups. In some communities with multiple interagency groups, different Early Head Start staff members represented the program at group meetings. These staff members were responsible for sharing information from the meetings with other Early Head Start staff.

Program staff in all the programs communicated frequently with other community service providers and described their relationships with them as cooperative or very cooperative. Most programs reported that they communicated with more than one other provider at least monthly and often weekly. In most programs, at least 85 percent of staff members described their relationships with other community agencies as cooperative or very cooperative.

At the time of the site visit, all the research programs either had formed or were forming a health advisory committee of community members. Many programs had also formed other advisory committees. Five had formed general advisory committees or used the grantee's general advisory committee. Three had formed an advisory committee on education, social services, parent involvement, and/or employment and training. Two programs had formed an advisory committee on child care, and a third was in the process of forming one at the time of the site visit. Two programs had boards of directors or were advised by the grantee's board of directors, and one program had formed a research advisory committee.

F. PROGRAM MANAGEMENT AND CONTINUOUS IMPROVEMENT

The site visits did not include a review of management procedures, but the topics of discussions with program directors included community needs assessments, program implementation plans, and continuous program improvement strategies. Strong management, self-assessment, and continuous program improvement activities are particularly important because the programs were new, and they were operating in a dynamic world in which social policies and families' needs were changing.

1. Program Planning

All the programs conducted their own community needs assessment or relied, either entirely or in part, on assessments done by other community organizations. Programs used these community needs assessments initially to document the need for the Early Head Start program, and later to develop program implementation plans.

Most programs had written implementation plans at the time of the site visits. In many programs, these plans were undergoing revision. Several programs that were operated by Head Start grantees were incorporating Early Head Start's implementation plans into those of the agency to create an integrated plan for children age 0 to 5. One program was in the process of completing manuals to present its implementation plans and best practices for serving families.

2. Continuous Program Improvement

Many programs (eight) conducted regular formal self-assessments to take stock of their progress in serving families. In addition, six programs either were planning to conduct a formal self-assessment or were engaged in informal self-assessment activities. At the time of the site visit, three programs did not report engaging in self-assessment activities.

Most programs had partners to help them with continuous program improvement. Nine programs worked with their local research partner on it, and three worked with other partners. In five programs, internal staff members were responsible for such activities.

The improvement activities focused on several areas. Six programs mentioned discussions with their local research partner about theories of change, program outcomes, or intervention strategies as components of their activities. Six programs focused on identifying and addressing staff training needs, and six convened regular meetings to assess implementation and discuss changes. Five focused on documenting and assessing program services in their continuous improvement activities.

All except one of the research programs had a local research partner.[11] Even partners that were not also the program's continuous improvement partner sometimes provided feedback that was useful to the program.

3. Training and Technical Assistance

By fall 1997, many programs had drawn on technical assistance resources available to them through Head Start's training and technical assistance network. In fall 1997, this network included a network of 16 regional Technical Assistance and Support Centers (TASCs) and a network of 12 regional Resource Access Projects (RAPs).[12] In fall 1997, 11 Early Head Start research programs reported receiving training or other key support from their TASC representative, and 9 programs reported receiving training or other key support from their RAP representative. In another program, staff members had met recently with TASC and RAP representatives to assess the program's training and technical assistance needs.

Another element of the Early Head Start training and technical assistance network is the Early Head Start National Resource Center operated by Zero to Three: National Center for Infants, Toddlers and Families and WestEd's Center for Child and Family Studies. Zero to Three staff visited the research programs during the early phase of their implementation and in many cases, provided key support to the programs. Zero to Three also organizes an annual Institute for Programs

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[11] One of the two programs that ACYF added to the research had not applied with a local research partner to be part of the research and did not have a local research partner. The other program that ACYF added was located near another research program, and the local researcher for that program became the local partner for the added one.

[12] Shortly after the site visits were completed, the system was reorganized, and training and technical assistance is now provided by regional Quality Improvement Centers (QICs) and Disabilities Services Quality Improvement Centers (DSQICs).

Serving Pregnant Women, Infants, Toddlers, and Their Families, which presents information and training on a wide range of topics. Many program staff also attended training offered by WestEd on caring for infants and toddlers.

In addition to training and technical assistance they received through the Head Start network, many of the research programs took advantage of training and technical assistance available from other organizations in their community or state. They also received key support from their federal program officer.

IV. EARLY IMPLEMENTATION CHALLENGES AND SUCCESSES

The fall 1997 site visits offered an opportunity to learn about the challenges that Early Head Start programs faced in their early phases. The visits were conducted at the end of the second year of program funding and the first year of serving families. Some programs were just getting off the ground, while others were adding Early Head Start to an existing Head Start program or making a transition from previous operations as a CCDP or a Parent Child Center. All the programs faced new challenges, but they also exhibited key strengths and demonstrated some early successes.

A. EARLY CHALLENGES

In examining the first year that the 17 research programs served families, we identified a number of challenges that several programs faced. Some challenges reflect the programs' early stage of implementation. Others reflect the difficulties associated with transitioning to a new program model. In addition, the programs were struggling to adjust to new realities and family needs in the wake of welfare reform.

1. Reaching and Maintaining Full Enrollment Was Challenging for Some Programs.

For some programs, the research eligibility criteria or the random assignment process made it harder to recruit families, and the need to recruit twice as many families made it harder to meet the deadline for full enrollment. Beyond the initial difficulties in recruitment, some of the programs had a hard time retaining families, and several had lost some families by the time of the site visits. The enrollment turnover in these programs had a number of causes: (1) some families did not fully understand the commitment required and did not want to participate at the expected levels, or they wanted different services than those offered by the program; (2) families moved out of the area; (3)

contact with families lapsed during periods of staff turnover; and (4) other commitments or family stresses interfered with the ability of families to participate.

2. The Transition to Providing Child-Focused Services Was Challenging for Some Programs with a History of Providing Family Support Services and Programs Whose Original Service Plans Were Family-Focused.

Staff of several programs, some of which were former CCDPs, initially believed that the best way to improve children's development was to address parents' problems and improve their parenting skills, so program services centered on parents. However, during the first year of program operations, the Head Start Bureau directed all Early Head Start programs to focus more on children and urged them to place priority on enhancing child development during home visits and on helping families arrange high-quality child care. This guidance required the staff in these programs to think and work in new ways, which some staff members resisted.

3. Ensuring High-Quality Child Care for Families Who Need It Posed a Substantial Challenge for Most of the Programs.

Families' needs for child care were increasing under welfare reform, and many families needed child care beyond the hours that center-based Early Head Start care was available. At the time of our site visits, the majority of the home-based and mixed-approach programs were not doing much to help these families find high-quality child care arrangements (beyond what the programs offered). Initially, the requirement that programs oversee the quality of care received by Early Head Start children in community child care settings was not clear to some programs. Plans for providing this oversight were being developed at the time of the site visits.

Programs that did not provide child care had to work with community providers to arrange care for program children. In many areas, program staff members reported that the quantity and quality of child care available for infants and toddlers in the community was inadequate. State regulations and child care subsidy levels set a low threshold for child care quality, and only programs with resources to supplement subsidies could provide higher-quality care.

Assessing and monitoring community child care arrangements also posed challenges. In programs where many children were cared for by relatives or neighbors, staff members either did not know much about children's child care arrangements or viewed assessing and monitoring the arrangements as inappropriate. In any case, whether the child care provider is a relative or a child care center, assessing and monitoring the quality of the care provided requires the cooperation of the provider. It also requires considerable staff resources. For some programs, assessing and monitoring child care, in addition to completing home visits and other activities, stretched staff resources beyond their limits.

Staff turnover in community child care settings can also pose a significant challenge to enhancing the quality of community child care through staff development. Often the best strategy (and one chosen by several of the Early Head Start research programs) is to provide training and technical assistance to caregivers, because lowering child-staff ratios and reducing group sizes, for example, requires substantial financial resources. Investments in caregiver training, however, may not be very effective in increasing child care quality if the caregivers who receive the training leave their jobs after a short time.

4. A Number of Programs Were Not Successful in Engaging the Majority of Parents and Children in the Required Group Socialization Activities.

Most of the programs offering home-based services were offering regular group socialization activities for parents and children in fall 1997. However, finding times when parents were available to attend group socialization activities was challenging for many programs. Many parents faced other demands on their time, and attending group socialization activities was not their highest priority. In one program, relying on home visitors to make sure parents received information about group socialization activities caused parents to be informed inconsistently about the group activities. Some programs found that it took a while for some parents to feel comfortable in group activities.

5. Meeting the Required Schedule of Weekly Home Visits for Families Receiving Services Through the Home-Based Option Was Challenging for Most Programs.

Welfare reform now requires many low-income parents to work or participate in work-related activities, so many parents had less time available to meet with home visitors. Moreover, the welfare time limits and the clear message that welfare recipients must work caused many parents to give priority to looking for jobs and working rather than participating in program activities, including home visits. To address this issue, some programs attempted to schedule more home visits during evening hours, after parents had returned from work. However, some home visitors found that parents and children were often too tired at the end of the day and too busy preparing for the next day's activities to participate satisfactorily.

Beyond the demands of welfare reform, the chaotic, disorganized lives of some families made it difficult for them to keep appointments for home visits. Home visitors often tried to reschedule missed visits but could not always fit makeup visits into their schedules.

6. Adding Early Head Start to Head Start Services Was a Challenging Adjustment for Some Programs.

Staff members who moved from Head Start to Early Head Start had to adjust to new responsibilities. Staff accustomed to serving families with older children needed to shift their focus to the special needs of families with infants and toddlers. When training for Early Head Start and Head Start staff was integrated, however, the activities sometimes appeared to lack a focus on infants and toddlers.

Moving from Head Start to Early Head Start also required adjustments to work schedules and work activities. Some staff members making the shift did not like the change from a part-year to a full-year schedule that came with joining Early Head Start. Other staff members found caring for infants to be harder work than they expected and transferred back to Head Start.

Adding Early Head Start to Head Start was not always difficult, but when there were staffing or administrative problems within the Head Start program, and Early Head Start was perceived as competing for resources, tensions sometimes arose among staff members. Lack of communication between Early Head Start and Head Start staff members also caused difficulty in some programs.

7. Home Visitors and Center Teachers in Many of the Programs Expressed Dissatisfaction with Their Wages.

Consistent with other programs, the Early Head Start programs paid low wages to these staff members. The average hourly wage of $9.77 amounts to an annual salary of about $20,000, not far above the poverty level. Many staff members, though largely satisfied with their jobs, felt that their wages were inadequate.

Wages at this level in child care programs have been associated with high staff turnover rates, which, not surprisingly, some of the research programs had suffered. Moreover, at least one program reported having difficulty filling open positions, because of the salaries they were offering.

8. Leadership Changes and Staff Turnover in Several Programs Created Staff Morale Problems and Disrupted Services to Families.

Improving staff morale and re-engaging families were important challenges for new staff members. Difficulties leading up to changes in program managers often resulted in low staff morale. When this happened in three of the research programs, the new program managers had to work with staff members to restore their confidence in the program's leaders and rekindle their enthusiasm for their jobs.

In some of the four programs that experienced high rates of turnover in frontline workers, some families experienced disruptions in services. It was not always possible to replace staff members immediately, and the remaining staff members could not step in and do all the work of the ones that had left.

Many of the programs operate on the sound principle that effective work with families requires trusting relationships with parents. Staff turnover dissolved these bonds and compelled replacement staff members to rebuild them, even when programs were able to continue some level of services.

B. EARLY STRENGTHS AND SUCCESSES

Despite the challenges of implementing a new program in a changing environment, the Early Head Start research programs had made substantial progress by fall 1997 toward implementing the Early Head Start model as envisioned by program planners.

1. At the Time of the Site Visits, the Programs Were Increasing Their Focus on Child Development.

Many programs began with a strong child development component. Others with a history of focusing on family support services were making considerable progress in strengthening child development services, with help from training and technical assistance providers. In particular, home-based programs were encouraging home visitors to spend time on child development during visits, even when other family needs were pressing. In addition, training and technical assistance providers were helping home-based programs to take an active role in obtaining high-quality child care for families that needed it.

2. The Programs' Operating Centers Maintained Low Child-Caregiver Ratios.

Most of the center-based and mixed-approach programs reported that they maintained child-caregiver ratios that met the Revised Head Start Performance Standards, and many also reported meeting the group size requirements. The child-caregiver ratio and group size requirements are set at levels that most experts consider to constitute a threshold for good-quality child care. For example, the group sizes and ratios specified in the Revised Head Start Performance Standards are within the range required for accreditation by the National Association for the Education of Young Children for infants, and better than the accreditation standards for toddlers. Several of the EHS centers had received or were in the process of obtaining NAEYC accreditation in fall 1997.

3. The Programs Included a Strong Focus on Helping Families Obtain Physical and Mental Health Services.

Many of the research programs had developed strong partnerships with providers of health care services to families. With the help of their partners, many programs provided health education, health screenings, health care, and counseling.

4. Many Research Programs Were Making Special Efforts to Involve Fathers in the Lives of Their Children and in the Early Head Start Program.

Many programs not only encouraged fathers to be involved in their children's lives and to participate in program activities, but also designed special activities for them. Although the levels of participation by fathers were often low, many programs had succeeded in engaging a core group of fathers in the special activities. These fathers may be able to help the programs build interest among other fathers and increase levels of participation in the future.

5. All Programs Offered Substantial Staff Training and Support to Staff Members.

The research programs, especially home-based and mixed-approach programs, hired well-educated staff members, and all of the programs provided substantial training, supervision, and support for frontline staff members. Most of the programs reported that staff members received preservice orientation and training, and in some programs, the preservice training was extensive. All programs provided regular staff in-service training, either in group sessions or through individual observation and feedback.

All programs also reported convening regular staff meetings, usually weekly, in which supervisors provided group supervision and support. These meetings also gave staff members opportunities to provide and receive peer support. Program leaders also worked with staff individually to help them review their work and address difficult issues as they arose.

6. Staff Members Expressed a Strong Commitment to Their Program During the Site Visits and in the Staff Survey.

The research programs have succeeded in creating pleasant and supportive work environments and in building committed staffs that work very hard to accomplish program goals. It appears that the investments that programs made in staff development and the resources they devote to supporting frontline staff members enable them to foster staff commitment despite the low wages they pay.

The supportive work environments created by the research programs are also reflected in the modest proportion of staff members who reported that their job was consistently stressful. Despite the high levels of needs and difficult circumstances of the families served by the programs and the challenges of serving such families, only about one-fourth of staff members reported that their job was always or usually stressful.

7. The Early Head Start Research Programs Had All Forged Strong Community Partnerships and Were Participating Actively in Community Collaborative Groups.

All the programs had community partners and worked with other agencies to help meet families' needs. Staff members at all levels often collaborated with workers in other agencies to coordinate services for families.

Early Head Start staff members often played leadership roles in community collaborative groups. In addition, some programs involved all staff members in broader collaborative activities by making them responsible for attending meetings, serving as liaisons, and sharing information with other Early Head Start staff members.

8. All the Early Head Start Research Programs Were Motivated by a Strong Desire to Improve Services to Children and Families.

Staff members' desire to improve was very evident in discussions during site visits, and continuous improvement efforts were integral to most programs. Their willingness to engage in self-reflection and their receptiveness to feedback are likely to help them learn from their early experiences and adapt to changes as they serve low-income families and children.

C. SUMMARY AND IMPLICATIONS

The challenges and successes highlighted in this chapter are those that the research programs experienced in the initial phase of implementing Early Head Start services. The programs are continuing to grow and change, and based on site visits in late summer 1999, we will provide a report on the pathways they have followed in meeting the challenges of serving low-income families with infants and toddlers and adapting to changes in the needs of children and families, changes in their communities, and changes in their national and local policy context. This report will describe the pathways programs took to providing high-quality Early Head Start services.

Some aspects of the research programs' early experiences were unique. Participation in the research sometimes made recruiting and enrolling families more difficult. In addition, because they were among the first programs funded, the research programs began before the revised Head Start Program Performance Standards were enacted and while program monitoring procedures and policy interpretations were being developed.

Nevertheless, many of the challenges the research programs faced in their first year of serving families were not unique and may be encountered by other new Early Head Start programs in the future. The research programs' early implementation experiences suggest several key areas in which some new Early Head Start programs may encounter difficulties and may benefit from training and technical assistance, including:

- Making transitions from providing other types of services, such as transitions from family-focused to child-focused services (for programs with a history of providing family support services) and transitions from serving preschool-age children to serving infants and toddlers
- Designing strategies for ensuring that program families receive high-quality child care (especially home-based programs)
- Completing home visits as frequently as desired
- Designing and conducting group socialization activities that meet families' needs and fit in their schedules
- Fostering strong staff commitment and minimizing staff turnover

The work of the research programs and their local and national research partners suggests that discussions of goals, strategies, and expected outcomes (theories of change) can be useful to young programs, as well as researchers. The discussions so far have helped some program staff think systematically and critically about their goals and strategies. The discussions are also helping researchers identify the research programs' priority outcomes and create analysis plans that focus on assessing impacts on specific outcomes in programs that are explicitly targeting them.

The research programs are leading the way, both as members of the first two waves of Early Head Start programs and as participants in the National Early Head Start Research and Evaluation project. As leaders, they are paving the way for new programs, sharing the lessons they have learned by engaging in a partnership with researchers that will enhance the relevance and usefulness of the evaluation research.

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